

MARYLAND STATE DEPARTMENT OF HEALTH

00196

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 35

212

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>COCKEYSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WHITE HALL RD.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>YORK RD.</u>		STREET ADDRESS (If rural, give location) <u>12 x 2</u>	
3. NAME OF DECEASED (Type or Print) <u>ADAMS JOHN ROY</u>		4. DATE OF DEATH (Month) <u>JAN</u> (Day) <u>20</u> (Year) <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>9-2-00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garage Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>55</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN HENRY ADAMS</u>		14. MOTHER'S MAIDEN NAME <u>HENRIETTA MON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-34-4726</u>	
17. INFORMANT AND ADDRESS <u>WIFE - Nola R. Adams</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>420.1</u>	(a) <u>MYOCARDIAL INFARCTION</u>	<u>1 Min.</u>
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>	<u>3 YRS.</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE William G. Pillsbury (Degree or title) M.D. ADDRESS Tamona DATE SIGNED 1/20/56

23. REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 23-56</u>	<u>Bethel</u>	<u>Madonna Harford MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1-22-56</u>	<u>Mrs Howard S. Markline</u>	<u>1100 1/2 Rte 1, Beltsville</u>	<u>MD</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JAN 27 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00197

## CERTIFICATE OF DEATH

Reg. Dist. No. 3/

213

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hebbsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hebbsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rolling Road &amp; Clays Ln.</u>		STREET ADDRESS (If rural, give location) <u>Rolling Road &amp; Clays Ln.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Annie E. Ahring</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 9, 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>3/20/ 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>73</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>William E. Ahring</u>		14. MOTHER'S MAIDEN NAME <u>Mollie R. ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>James Klaus PO 7664 Balto, 7, Md.</u>			

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) <u>Coronary Thrombosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>
Antecedent cause(s) (b) <u>Hypertensive Cardio-Vascular Renal Disease</u>	<u>10 wks.</u>
(c)	

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 10, 1953, to January 9, 1956, that I last saw the deceased alive on 1/9/56, 1956, and that death occurred at 2:01 P.M., from the causes and on the date stated above.

SIGNATURE <u>Edwin L. Simpson, M.D.</u>	(Degree or title)	ADDRESS <u>8204 Lehigh Rd, Balto 7, Md</u>	DATE SIGNED <u>1/10/56</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan. 13.56</u>	NAME OF CEMETERY OR CREMATORY <u>Western</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
DATE REC'D BY LOCAL REG. <u>1-11-56</u>	REGISTRAR'S SIGNATURE <u>Aug. L. Bonsall</u>	24. FUNERAL DIRECTOR <u>John T. Stansbury</u>	ADDRESS <u>6411 Windsor Mill Balto. 7 Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8204

BUREAU V. S.

JAN 24 1956

RECEIVED



1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AIBC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

214

## CERTIFICATE OF DEATH

00198

Reg. Dist. No. 30

Item 9, Film 92 2-6-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Balto.</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>128 Rosewood Ave.</u>				STREET ADDRESS (If rural give location) <u>128 Rosewood Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Anna</u> (Middle) <u>McGraw</u> (Last) <u>Anderson</u>				(Month) <u>Jan.</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>March 16, 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John A. McGraw</u>				14. MOTHER'S MAIDEN NAME <u>Jane E. Dillo</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>--</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Miss Agnes McGraw 128 Rosewood Av</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>4200</u>				<u>Coronary Thrombosis</u>			
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Hypertensive Cardio Vascular Disease</u>			
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/5/56</u> , 19 <u>56</u> , to <u>1/1/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/1/56</u> , and that death occurred at <u>9:45 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>17107 Edmondson Ave. (28) Md</u>		DATE SIGNED <u>1/3/56</u>			
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-4-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peters Cem.</u>		LOCATION (City, town, or county) (State) <u>Harford County, W. Va.</u>	
24. REC'D BY REGISTRAR DATE <u>JAN 10 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Fowler Funeral Home, Catonsville, Md.</u>			

# CERTIFICATE OF DEATH

312

BUREAU V. S.

JAN 11 1956

RECEIVED

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-45 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

215

## CERTIFICATE OF DEATH

00199

Reg. Dist. No. 38

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>TOWSON</u>		<u>18 yrs.</u>		TOWN <u>TOWSON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Stella Maris Hospice</u>				STREET ADDRESS (If rural give location) <u>Pot Spring Rd-</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Elizabeth Magdalene Angelvine</u>				<u>1-1-1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>F</u>	<u>W</u>	<u>W</u>	<u>Feb 27 1883</u>	<u>72</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Housewife</u>		<u>??</u>		<u>Penna.</u>		<u>U.S.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John Wise</u>				<u>Clara Doehler</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>NO</u>		<u>??</u>		<u>HOSPICE RECORDS</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>442X IMMEDIATE CAUSE (A)</b>				<u>Acute Pulmonary Edema</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>				<u>Hypertension &amp; Cor-dia-</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>				<u>Renal Vascular Dec-10 yrs.</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>March 1955</u> to <u>Jan 1, 1956</u>, that I last saw the deceased alive on <u>Dec 31, 1955</u>, and that death occurred at <u>8:27 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<u>Charles F. O'Donnell M.D.</u>				<u>2501 York Rd - Towson</u>		<u>Jan 1/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>1/3/56</u>		<u>Mt. Olivet Cemetery</u>		<u>Frederick, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>JAN 4 1956</u>		<u>Mabel Gray</u>		<u>John A. Moran</u>		<u>3000 E. Baltimore St.</u>	

BUREAU V.

JAN 4 1968

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00200  
215  
CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>X</u> TOWN <u>Ruxton</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Balto/</u> <u>3601-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorenson Nursing Home</u>				STREET ADDRESS (If rural give location) <u>3624 Greenmount Ave.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>CORA</u>		(Middle) <u>M.</u>		(Last) <u>ARMELING</u>	
4. DATE (Month) OF DEATH: <u>Jan.</u>		(Day) <u>27,</u>		(Year) <u>19 56</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Jan. 30, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>II</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>never worked</u>			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>William G. H. King</u>				14. MOTHER'S MAIDEN NAME: <u>Julia Conrad</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Ave. Mrs. Rita M. Schilling - 3624 Greenmount</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinomatous metastasis</u>						<u>1 year</u>	
ANTECEDENT CAUSE (B) <u>Myocarditis chronic</u>						<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertrophy myocardium C failure</u>						<u>2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Carcinoma intestinal.</u>						<u>unknown</u>	
19A. DATE OF OPERATION: <u>Dec. 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Refer to Union Memorial Hosp. (Colostomy)</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>		21C. WHERE DID (City or town) INJURY OCCUR? <u>no injury</u>		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>no injury</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>no injury</u>			
22. I hereby certify that I attended the deceased from <u>Jan 16, 1956</u> to <u>Jan 27, 1956</u> that I last saw the deceased alive on <u>Jan 20, 1956</u> , and that death occurred at <u>11:30 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James Graham Martin</u>		ADDRESS <u>M. D. 516 Cathedral Street</u>		DATE SIGNED <u>Jan 28-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/30/56</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>January 28 1956</u>		REGISTRAR'S SIGNATURE <u>Rar.</u>		FUNERAL DIRECTOR <u>St. M. J. Viskner &amp; Son - Balto 17nd</u>		ADDRESS	





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00201  
217 CERTIFICATE OF DEATH Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>1yr 2 1/2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cockeysville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>Cockeysville Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Gertrude Virginia Aspden</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>January 4, 1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>10-7-1872</u>	9. AGE last birthday <u>83 yrs.</u>		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry Arment</u>				14. MOTHER'S MAIDEN NAME: <u>Van Luvanie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>			DUE TO				
ANTECEDENT CAUSE (B) <u>Arteriosclerotic cardiovascular disease</u>			DUE TO				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-11-1954</u> to <u>1-4-1956</u> , that I last saw the deceased alive on <u>1-4-1956</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Stella Wachter</u>		ADDRESS <u>Spring Grove State Hospital</u>		DATE SIGNED <u>1-4-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 7 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Towson, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-6-56</u>		REGISTRAR'S SIGNATURE <u>V.E. Harris</u>		FUNERAL DIRECTOR <u>John Burns</u>		ADDRESS <u>Anna Towson, Md.</u>	



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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 213 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

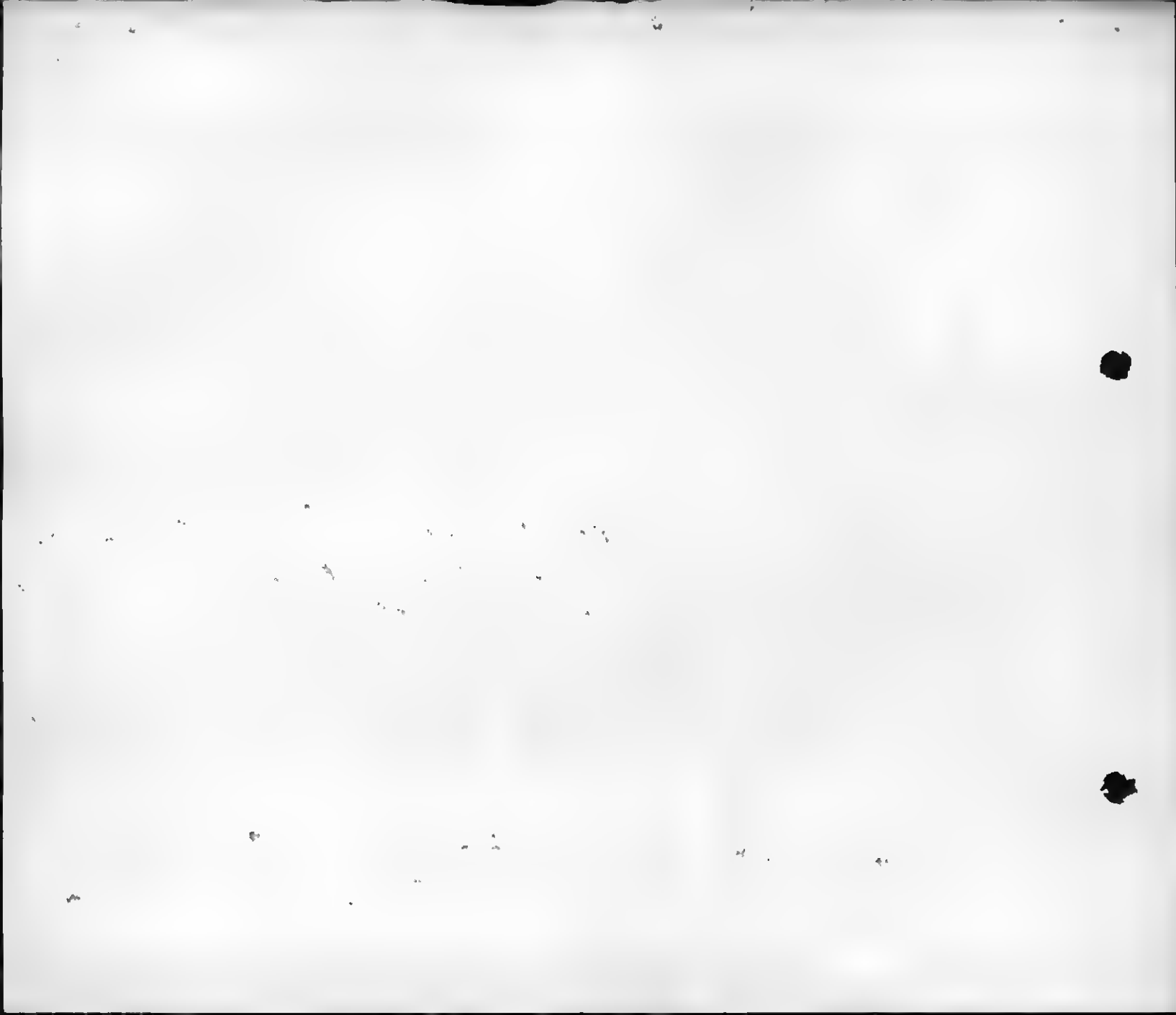
Item 2 ByPhone -Nursing Home 1-31-55 ans

## CERTIFICATE OF DEATH

Reg. Dist. No.

00202

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND	STATE <u>Md</u> COUNTY <u>Baltimore</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>	OR TOWN <u>Middle River</u>	STREET ADDRESS (If rural give location) <u>261 S. Ellwood Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Long Hall Conv Home</u>			
3. NAME OF DECEASED: (First) <u>Wilson</u> (Middle) <u>Auld</u> (Last) <u>Auld</u>		4. DATE (Month) <u>Jan</u> (Day) <u>29</u> (Year) <u>1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Dec 5 1877</u>
9. AGE last birthday <u>78</u> yrs. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		10. AGE last birthday IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>B.O.R.R. ret.</u>	
11. BIRTHPLACE (State or foreign country): <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Benjamin L Auld</u>		14. MOTHER'S MAIDEN NAME: <u>Catharine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>(If Yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mr. Mary Hessebaum Walther</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Parkinson's Disease</u>	DUE TO	<u>5 yrs</u>	
ANTECEDENT CAUSE (B) <u>arterio-sclerotic heart disease</u>	DUE TO	<u>8 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>vascular disease</u>	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 7, 1955</u> to <u>Jan 29, 1956</u> , that I last saw the deceased alive on <u>Jan 18, 1956</u> , and that death occurred at <u>9:10 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Joseph M. Glick</u>		ADDRESS <u>423 Eastern Ave</u> DATE SIGNED <u>1/29/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/1/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		LOCATION (City, town, or county) (State) <u>Balto</u>	
DATE REC'D BY LOCAL REGISTRAR <u>30-18</u>		REGISTRAR'S SIGNATURE <u>C</u>	
24. FUNERAL DIRECTOR <u>Ullrich Funeral Home</u>		ADDRESS <u>4210 Belair Rd</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*Model Certificate*

219

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00203

Reg. Dist. No. 45

Items 13, 17: film G193 2-27-56 L

1. PLACE OF DEATH- COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Middle River Md.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Middle River, Balto., 20 Md.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <b>36 W. Midland Rd., Victory Villa</b>	
3. NAME OF DECEASED (Type or Print) <b>William A. Badders</b>		4. DATE OF DEATH (Month) <b>Jan.</b> (Day) <b>17</b> (Year) <b>1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	8. DATE OF BIRTH <b>May 3, 1909</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Construction</b>	9. AGE last birthday <b>46</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Pylesville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William A. Badders</b>		14. MOTHER'S MAIDEN NAME <b>Ida Shenberg/Shanbarger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>183-14-8404</b>	
17. INFORMANT AND ADDRESS <b>Orpha B. Badders, Middle River, Md.</b>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <b>(a) Hypostatic pneumonia</b>			<b>2 weeks</b>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>(b) Pulmonary TBC</b>			<b>6 yrs.</b>
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>1-17</b> , 19 <b>56</b> , to <b>1-17</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>1-17</b> , 19 <b>56</b> , and that death occurred at <b>6:30</b> p.m., from the causes and on the date stated above.			
SIGNATURE <b>Jack C. Collins, M.D., Penick Med Exam.</b>		ADDRESS <b>Balt 22</b>	
DATE SIGNED <b>1-17-56</b>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Jan. 20, 1956</b>	
NAME OF CEMETERY OR CREMATORY <b>Cokesbury</b>		LOCATION (City, town, or county) (State) <b>Abingdon, Harford, Md.</b>	
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son</b>		ADDRESS <b>Abingdon, Md.</b>	
DATE REC'D BY LOCAL REG. <b>1-24-56</b>		REGISTRAR'S SIGNATURE <b>Edith Hursey</b>	

BUNNELL V. S.

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RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been examined by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

00204

Reg. Dist. No. 38

220

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Towson</b>				TOWN <b>Towson</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>6508 Crestwood Road</b>				STREET ADDRESS (If rural give location) <b>6508 Crestwood Road #12</b>			
3. NAME OF DECEASED (Type or Print) <b>Mr. Francis (Frank) X. Baird</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>January 1st 1956</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>		8. DATE OF BIRTH <b>Oct. 8, 1886</b>	
				9. AGE last birthday <b>69</b> yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer, Heating &amp; Ventilating Co</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>Mr. William J. Baird</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Walsh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>216-01-3021</b>				17. INFORMANT & ADDRESS <b>Mrs. Florence M. Baird, 6508 Crestwood</b>			
16. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Terminal Stage Carcinoma</b>						<b>one year.</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Lungs.</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>none</b>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <b>none</b>		19b. MAJOR FINDINGS OF OPERATION <b>none</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, etc.) OF INJURY <b>street, office bldg., etc.</b>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <b>2:30 A.M.</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>8400 Loch Raven Blvd.</b>			
22. I hereby certify that I attended the deceased from <b>July 1955</b> to <b>Jan. 1, 1956</b> that I last saw the deceased alive on <b>Dec. 30, 1955</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Joseph F. Li Pin</b>				ADDRESS (Street, city, town, state) <b>8400 Loch Raven Blvd.</b>		DATE SIGNED <b>1-2-56</b>	
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Jan. 1, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Mt. Maria Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore Co, Maryland</b>	
24. REC'D BY REGISTRAR <b>Mabel Gray</b>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Harford Road #14</b>	

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BURTON V. S.



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

00205

38

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>55 TOWNS</b>		LENGTH OF STAY (In this place) <b>Towson</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>55 TOWNS</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00 8462 Loch Raven Blvd</b>				STREET ADDRESS (If rural give location) <b>8462 Loch Raven Blvd</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Mrs. Elsie G. Banister</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>January 8th 19 56</b>			
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>W and D</b>	<b>8. DATE OF BIRTH</b> <b>Oct. 28, 1898</b>		<b>9. AGE last birthday</b> <b>57 yrs.</b>	<b>IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Sales Lady</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Valentine Hartman</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>?</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Beatrice K. Fiore, 8462 Loch Raven</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>420.1 IMMEDIATE CAUSE (A)</b> <b>Coronary artery thrombosis</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Hypertensive cardiac involvement</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 1/5, 1956, to 1/8, 1956, that I last saw the deceased alive on 1/8, 1956, and that death occurred at 8:24 A.M. from the causes and on the date stated above. 1/9/56</b>							
<b>SIGNATURE</b> <i>E. J. Grace</i>				<b>DATE SIGNED</b> <i>1/9/56</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>DATE THEREOF</b> <b>Jan. 11, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Holy Redeemer Cem.</b>	
<b>24. REC'D BY REGISTRAR</b>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck, 5305 Harford Road #14</b>		<b>LOCATION (City, town, or county)</b> <b>Baltimore, Md.</b>	

RECEIVED

JAN 17 1953

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

#B: film G192 2-21-56 L : 222

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00206

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Catonsville		LENGTH OF STAY (In this place) 2 YRS.		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Catonsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 720 Meadowbrook Road				STREET ADDRESS (If rural, give location) 720 Meadowbrook Road			
3. NAME OF DECEASED: (Type or Print)		(First) DAVID		(Middle) AUGUSTUS		(Last) BARTH	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed		8. DATE OF BIRTH: Sept. 19, 1892	
						9. AGE last birthday: 63 yrs.	
						10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer	
						11. BIRTHPLACE (State or foreign country): Maryland	
						12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13. FATHER'S NAME: John Barth				14. MOTHER'S MAIDEN NAME: Mary M. Wolbert			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 219-12-8278		17. INFORMANT & ADDRESS: George H. Barth 720 Meadowbrook Road Catonsville 28, Md.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) ACUTE ALCOHOLISM							
Antecedent cause(s) (b) DEATH IS DUE TO NATURAL CAUSES							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (c) stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Jan. 25/56		Jennings Chapel Cemetery		Howard County, Maryland.	
23. BURIAL, CREMATION, REMOVAL (Specify):		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
1/24/56		T. E. Harry		Easton Sons, Catonsville 28, Md.			

100-100000

JAN 1 1950

100-100000

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 104

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

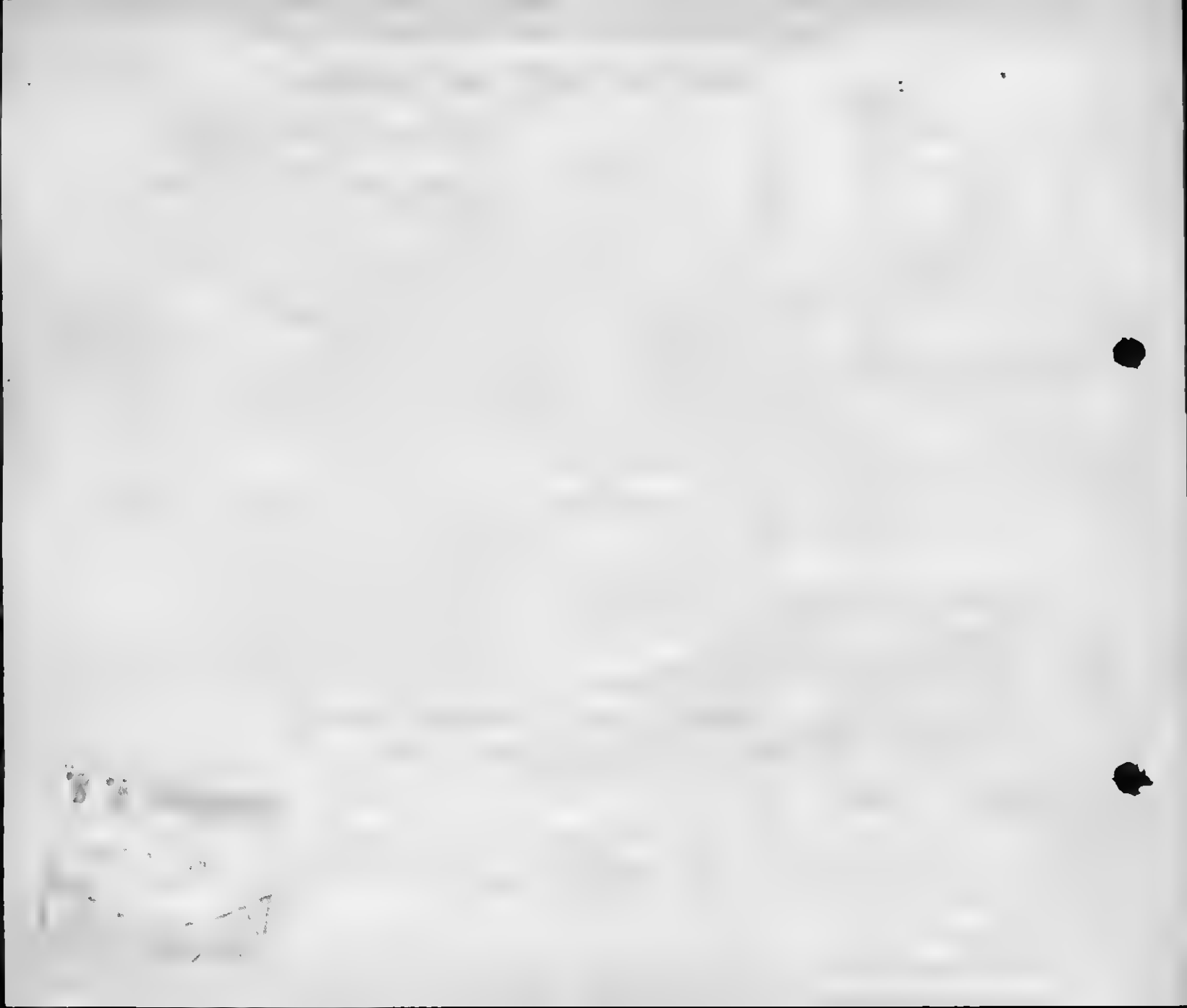
## CERTIFICATE OF DEATH

00207

Reg. Dist. No. ....

223

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md.</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Catonville</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Catonville</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hood Conv. Home</i>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Clarance W. Bathgate</i>				<b>4. DATE OF DEATH</b> (Month) <i>1</i> (Day) <i>5</i> (Year) <i>1956</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>R</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M</i>	8. DATE OF BIRTH <i>12-6-79</i>	9. AGE last birthday <i>76</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>LABORER</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <i>Charles</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Mullineaux</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO (If Yes, give war or dates of service)		17. INFORMANT'S ADDRESS <i>Family - Same</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <i>Emphysema - R Lung -</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3-days</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Generalized arteriosclerosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>...</i>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>DEC 31, 1955</i> to <i>JAN 5, 1956</i> , that I last saw the deceased alive on <i>JAN 5, 1956</i> , and that death occurred at <i>2:45 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>James H. Howell</i>				ADDRESS (Street, city, town, state) <i>Catonville</i>		DATE SIGNED <i>1-6-</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <i>1/9/56</i>		NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL</i>		LOCATION (City, town, or county) (State) <i>BH 110</i>	
24. REC'D BY REGISTRAR DATE <i>JAN 10 1956</i>		REGISTRAR'S SIGNATURE <i>V. E. Bump</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. E. Collip</i>		ADDRESS <i>55 N. Cal. Home</i>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

## CERTIFICATE OF DEATH

Reg. Dist. No.

00208

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Chesaco Park</u>		OR TOWN <u>Chesaco Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Patapsco Ave</u>		STREET ADDRESS (If rural give location)	<u>Putapsco Ave</u>
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Anne</u>	(Middle) <u>Maria</u>	(Last) <u>Bengel</u>	(Month) <u>Jan</u>
(Type or Print)			(Day) <u>28</u>
			(Year) <u>1956</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>W.H.T.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>Nov 20 - 1870</u>
			9. AGE last birthday: <u>85</u> yrs
			10. MONTHS: <u></u> DAYS: <u></u> HOURS: <u></u> MIN: <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife At Home</u>		11. BIRTHPLACE (State or foreign country): <u>Balto md</u>	
10B. KIND OF BUSINESS OR INDUSTRY:		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William Webb</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Weich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>J. Morris, Betz 2830 Pelham Ave</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			<u>2. hours</u>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>12/31/56</u> , and that death occurred at <u>12/31/56</u> M, from the causes and on the date stated above.			
SIGNATURE <u>J. Morris</u>		ADDRESS <u>Belt 22</u>	
DATE SIGNED <u>1/30/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/31/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Parthwood</u>		LOCATION (City, town, or county) <u>Balto.</u>	
(State) <u>md.</u>			
24. FUNERAL DIRECTOR		ADDRESS	
<u>LaSalle Funeral Home</u>		<u>7401 Belair Rd.</u>	



Dr. J. H. Collins  
Shirship Rd.  
Jan 11 9-11<sup>30</sup> A.M.

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00209

225

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Items 11, 12 Film 91 1-16-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u> MARYLAND				STATE <u>MD.</u> COUNTY <u>BALTO.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>North Market</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTO.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9 Accisari Ave</u>				STREET ADDRESS (If rural give location) <u>1613 E. 1st St</u>			
3. NAME OF DECEASED (First) <u>Berita</u> (Middle) <u>Benita</u> (Last) <u>Benita</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>9</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>1-19-76</u>	9. AGE last birthday <u>76</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <u>Family - Same</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 IMMEDIATE CAUSE (A) <u>urginia</u>						2 wks.	
2 ANTECEDENT CAUSE(S) DUE TO (B) <u>Nephrosclerosis</u>						1 yr.	
3 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Cardiovascular</u>						2 yrs	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1</u> , 19 <u>53</u> , to <u>Jan 9</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Jan 9</u> , 19 <u>56</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Walter Hammett</u>				ADDRESS (Street, city, town, state) <u>8552 Phila Rd Balto 6</u>		DATE SIGNED <u>1/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>1-13-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>BALTO.</u>	
24. REC'D BY REGISTRAR <u>Jan 12 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. Walter Hammett</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Jones</u>		ADDRESS <u>Home</u>	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Outside with Garden  
Vaporizer  
Cigarettes  
1 pack  
2.00

Jan 18

Handwritten notes at bottom, including dates and possibly names or locations, written in a cursive script.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00210

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>			
TOWN <u>BALTIMORE</u>		<u>12-19-56</u>		STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE STATE HOSP.</u>				<u>1295. LOUDON AV. BALTO. 10 - MD.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>HORACE</u> <u>B</u> <u>BEREAN</u>				<u>1</u> <u>19</u> <u>1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>M</u>	<u>W</u>	<u>W</u>	<u>8-8-72</u>	<u>63</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>INSURANCE AGENT</u>				<u>Travelers Ins. Co.</u>		<u>PENN.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>SAMUEL BEREAN</u>				<u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS.	
<u>unk.</u>				<u>unk.</u>		<u>HORACE BEREAN JR.</u> <u>300 GOODWOOD GARDENS BALTO. 10 MD.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE						<u>5 HOURS</u>	
(B) ANTECEDENT CAUSE (8' DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>GENERALIZED ARTERIOSCLEROSIS</u>							
(D) <u>ADVANCED AGE</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/19/1955</u> to <u>1/19/1956</u> that I last saw the deceased alive on <u>1/19/1956</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE		DATE SIGNED		ADDRESS			
<u>Stella Wachol</u>		<u>1/20/56</u>		<u>St. Joseph's Hospital</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>1/21/56</u>		<u>Greenmount Crematory</u>		<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>January 21, 1956</u>		<u>R.W.</u>		<u>Schimmek Funeral Home, Inc.</u>		<u>2601-3-5 E. Madison St.</u>	

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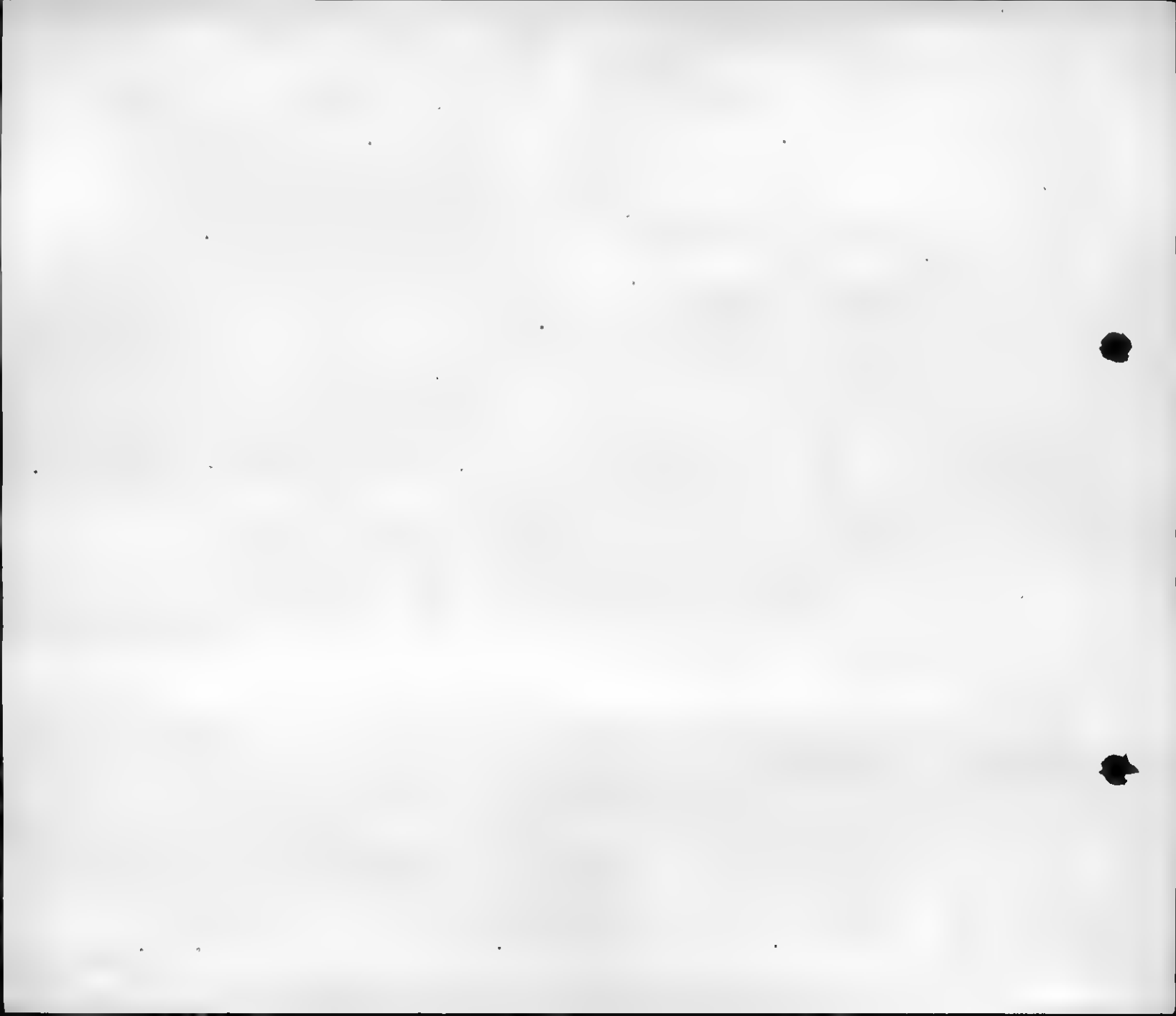
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Balto.</b>	MARYLAND	STATE <b>Md.</b>	COUNTY
CITY (If outside corporate limits, write RURAL or and give nearest town) <b>Catonsville</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>House-in-the-Pines</b>		STREET ADDRESS (If rural give location) <b>28 Augusta Ave.</b>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
(First) <b>MARGARET</b> (Middle) <b>I.</b> (Last) <b>BOEHNE</b>		(Month) <b>Jan.</b> (Day) <b>15,</b> (Year) <b>1956</b>	
5. SEX: <b>female</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>widowed</b>	8. DATE OF BIRTH: <b>Oct. 28, 1877</b>
9. AGE last birthday: <b>78</b> yrs		10. BIRTHPLACE (State or foreign country): <b>Md.</b>	
11. BIRTHPLACE (State or foreign country): <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Augustus Hirsch</b>		14. MOTHER'S MAIDEN NAME: <b>Anna Mary Foster</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <b>Mr. John F. L. Boehne, Jr.-413 Warren Ave.</b>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <b>12X</b>		<b>1</b>	
ANTECEDENT CAUSE (S)		<b>4 days</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <b>Pulmonary Defenses</b>			
(B) <b>Cerebral Thrombosis</b>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>1/11</b> , 19 <b>56</b> , to <b>1/15</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>1/15</b> , 19 <b>56</b> , and that death occurred at <b>6:17</b> M, from the causes and on the date stated above.			
SIGNATURE <b>James F. Hatzelberger</b>		DATE SIGNED <b>1/15/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1.18/56</b>	
NAME OF CEMETERY OR CREMATORY <b>Western Cem.</b>		LOCATION (City, town, or county) <b>Balto., Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>1-18-56</b>		REGISTRAR'S SIGNATURE <b>James F. Hatzelberger</b>	
24. FUNERAL DIRECTOR <b>Wm. J. Hatzelberger &amp; Sons - Balto 17 Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

00212

228

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

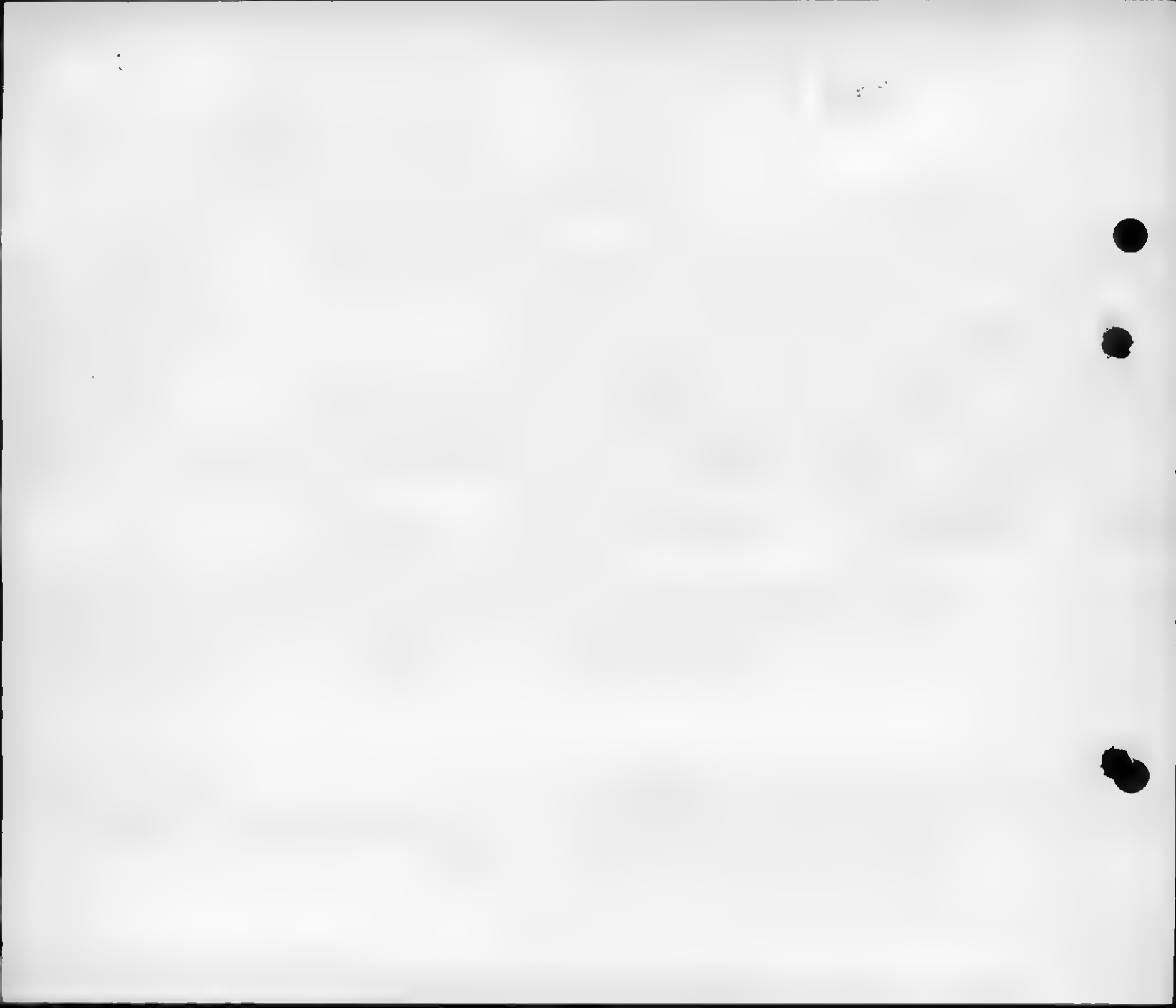
Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <b>Gray Manor</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>2414 Plainfield Avenue</b>				STREET ADDRESS (If rural, give location) <b>2414 Plainfield Avenue</b>	
3. NAME OF DECEASED (Type or Print) <b>Margaret</b>		(First) (Middle) (Last) <b>Bowers</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>January 8 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>March 4, 1873</b>	9. AGE last birthday <b>82</b> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Jacob Lightner</b>		14. MOTHER'S MAIDEN NAME <b>Magdalen</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <b>Mrs Elizabeth Rossback 2414 Plainfield Av</b>	
18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>Pulmonary edema, acute</b>					<b>30 mins.</b>
Antecedent cause(s) (b) <b>Heart disease, giving rise to the above cause stating the underlying cause last</b>					<b>undel.</b>
(c) <b>Arteriosclerosis, generalized</b>					<b>undel.</b>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Diabetes</b>					<b>undel.</b>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <b>SUICIDE HOMICIDE</b>		PLACE (Home, farm, factory, street, office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m. <input checked="" type="checkbox"/> While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Dec 15, 1955</b> , to <b>Jan 8, 1956</b> , that I last saw the deceased alive on <b>Jan 7, 1956</b> , and that death occurred at <b>Jan 8, 1956</b> , from the causes and on the date stated above.					
SIGNATURE <b>J. Beall, M.D.</b>		ADDRESS <b>434 Eastern Ave East Md</b>		DATE SIGNED <b>1/9/56</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Jan 12, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>	
LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc., 403 S. Wolfe St.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

229

## CERTIFICATE OF DEATH

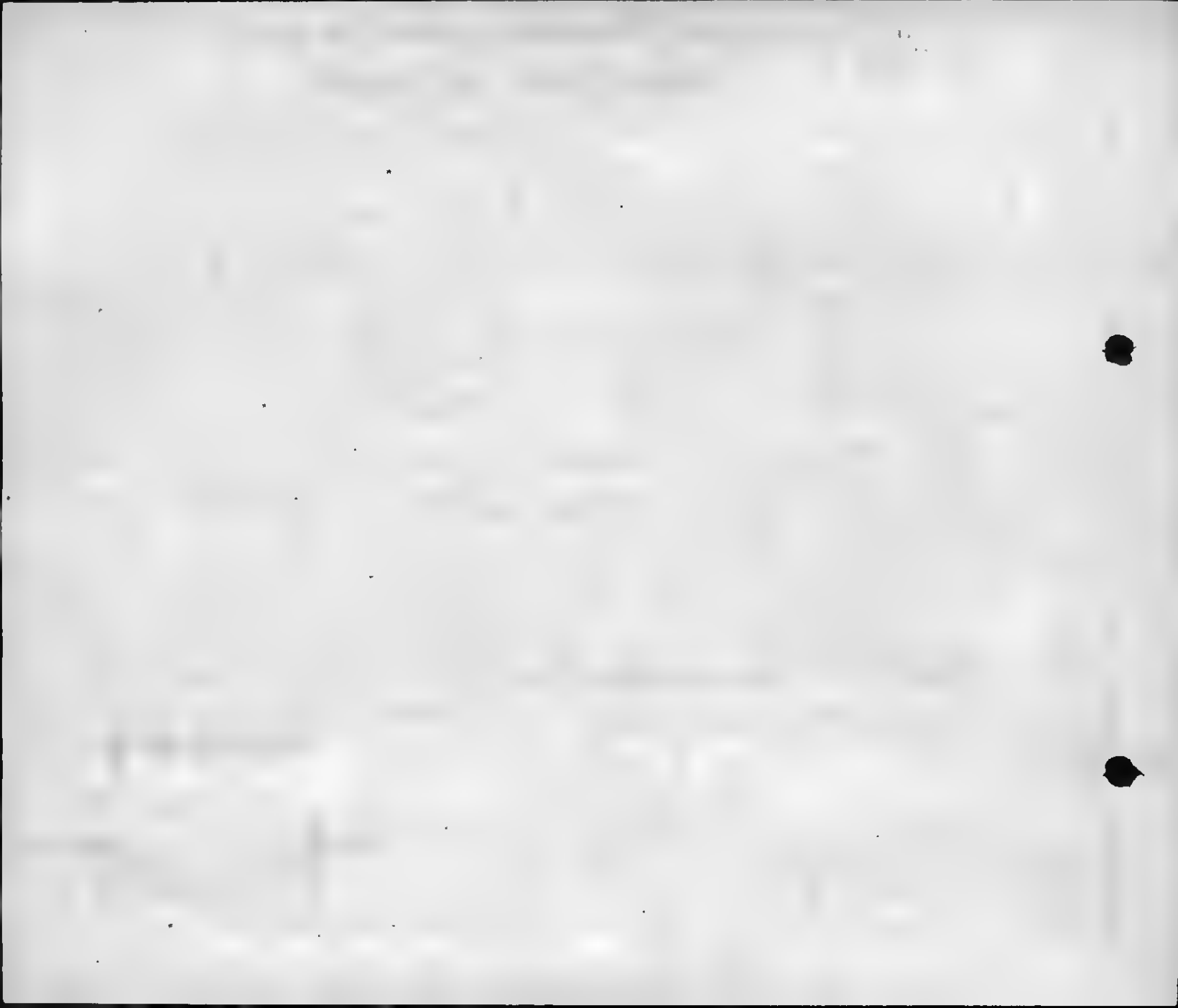
00213

38

Items 8,9 FilmGL92 2-20-56 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8201 Pleasant Plains Road</u>				STREET ADDRESS (If rural give location) <u>8201 Pleasant Plains Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>MARY ELLEN BOWERS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 12th, 19 56</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>March 22, 1880</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard Bowers</u>				14. MOTHER'S MAIDEN NAME <u>Annie Carter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Miss Mae Bowers, 8201 Pleasant Plains Rd.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>hypertension</u>						<u>4 yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes mellitus</u>						<u>1 yr</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>December 10, 19 56</u> to <u>January 12, 19 56</u> , that I last saw the deceased alive on <u>January 10, 19 56</u> , and that death occurred at <u>10 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Michael E. Gray</u> M.D. <u>4808 E. Pratt St.</u>				ADDRESS (Street, city, town, state) <u>Long Green, Md.</u> DATE SIGNED <u>1/15/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>1/16/56</u>		NAME OF CEMETERY OR CREMATORY <u>Wilson Methodist Cemetery</u>		LOCATION (City, town, or county) (State) <u>Long Green, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Michael E. Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wasserman Funeral Home</u>		ADDRESS <u>7401 Belair Road</u>	
DATE <u>1/15/56</u>							



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

230

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00214  
**CERTIFICATE OF DEATH**

Reg. Dist. No. 50

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
TOWN <u>Catonsville</u>				STREET ADDRESS (If rural give location) <u>924 N. Caroline Street</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Fusting Avenue</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 6, 1956</u>			
(Type or Print) <u>AUGUSTA G. BRANDAU</u>							
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Feb. 4, 1872</u>	9. AGE last birthday: <u>83</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>-----</u>				14. MOTHER'S MAIDEN NAME: <u>-----</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS: <u>Howell C. Brown, 5030 Edgar Terrace</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial Decompenation</u>						<u>12 hrs</u>	
ANTECEDENT CAUSE (B) <u>Chronic Hypertensive C. V. B. Disease</u>						<u>10 yrs (?)</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-3</u> , 1951, to <u>1-6</u> , 1956, that I last saw the deceased alive on <u>1-5</u> , 1956, and that death occurred at <u>6 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>William K. Gallagher</u>		ADDRESS <u>M.D. Catonsville-28, Md.</u>		DATE SIGNED <u>1/6/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>1/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Wm. Bart, Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The information copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00215

231

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>BALTIMORE</b>		STATE <b>MARYLAND</b>		STATE <b>MARYLAND</b>		COUNTY <b>ANNE ARUNDEL</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		LENGTH OF STAY (In the place) <b>101 DAYS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>PASADENA</b>		TOWN <b>PASADENA</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>RT. # 2 BOX 23</b>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>ELMER BRENNEMAN</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>JANUARY 19 1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>April 10, 1900</b>	9. AGE last birthday yrs. <b>55</b>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Pasadena, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William T. Breneman</b>				14. MOTHER'S MAIDEN NAME <b>Sadie E. MN: Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>216-16-4204</b>		17. INFORMANT & ADDRESS <b>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				UNKNOWN			
IMMEDIATE CAUSE (A) <b>AORTIC INSUFFICIENCY</b>				UNKNOWN			
ANTECEDENT CAUSE(S) DUE TO <b>HEALED ENDOCARDITIS, AORTIC VALVE</b>				UNKNOWN			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>PULMONARY EDEMA</b>				1 DAY			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Oct. 10, 1955</b> to <b>Jan. 19, 1956</b> and that death occurred at <b>11:15 PM</b> from the causes and on the date stated above.							
SIGNATURE <b>DONALD D. MARK, M.D.</b>				ADDRESS (Street, city, town, state) <b>VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>1/20/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1-23-56</b>		NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. REC'D BY REGISTRAR <b>Jan. 23, 1956</b>		REGISTRAR'S SIGNATURE <b>Dawson L. Larkley</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc. 6009 Harford Rd. Balto. Md.</b>			

U.S. AIR FORCE

JAN 1954

100-100000-1



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00216

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SORENSEN NURSING HOME 7912 RUXLEY RD</u>		STREET ADDRESS (If rural, give location) <u>8004 OAKLEIGH RD</u>	
3. NAME OF DECEASED (First) <u>CHARLES</u> (Middle) <u>LEO</u> (Last) <u>BROOKS</u>	4. DATE OF DEATH (Month) <u>1</u> (Day) <u>15</u> (Year) <u>1956</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11-23-1892</u> yrs. <u>73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PA. NW.</u>	9. AGE last birthday <u>63</u> Months <u>1</u> Days <u>15</u> Hours <u>15</u> Mins. <u>15</u>
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SHADRICK BROOKS</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE POWD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>717-07-7753</u>	
17. INFORMANTS <u>CHARLES L. BROOKS JR. 1722 FOREST ST.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Coronary Thrombosis</u> Sudden			
Antecedent cause(s) (b) <u>Hypertension &amp; arteriosclerosis for years</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Nephritis, chronic interstitial?</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		(STATE)	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, or office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12-3-55</u> , to <u>1-15-56</u> , that I last saw the deceased alive on <u>1-14-56</u> , and that death occurred at <u>6 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Anna L. Hall M.D.</u>		ADDRESS <u>Quinton Md</u> DATE SIGNED <u>1-16-56</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>1-18-56</u>	NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>	LOCATION (City, town, or county) <u>BALTO. Co.</u> (State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>1-16-56</u>	REGISTRAR'S SIGNATURE <u>Edna E. ...</u>	24. FUNERAL DIRECTOR <u>Elmer H. Conklin</u> ADDRESS <u>5444 BELMONT RD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

197  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00217  
Reg. Dist.

No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <b>Baltimore</b>		<b>1 Yrs.</b>		TOWN <b>Baltimore 22, Maryland</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1101 N. 4th St. Baltimore</b>				STREET ADDRESS (If rural, give location) <b>108 Hamlin Court</b>			
3. NAME OF DECEASED: (First) <b>EDNA</b>		(Middle) <b>MAE</b>		(Last) <b>BROWN</b>		4. DATE OF DEATH: (Month) <b>1</b> (Day) <b>16</b> (Year) <b>19 56</b>	
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>Jan-20-1923</b>	9. AGE last birthday: <b>32</b> yrs.		IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Home</b>		11. BIRTHPLACE (State or foreign country): <b>Youngstown Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME: <b>Unknown</b>				14. MOTHER'S MAIDEN NAME: <b>Mary Reed</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>2</b>		17. INFORMANT & ADDRESS: <b>John Brown 2 E</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<b>471</b> <b>Immediate cause</b> (a) ..... <b>Early bilateral bronchopneumonia</b> <b>DUE TO</b> <b>Antecedent cause(s)</b> (b) ..... Diseases or conditions, if any, giving rise to the above cause <b>DUE TO</b> stating underlying cause last (c) .....							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>William J. Brown</b>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <b>1/16/56</b>	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>Jan-20-56</b>		NAME OF CEMETERY OR CREMATORY <b>St Calvary C.</b>		LOCATION (City, town, or county) (State) <b>Brooklyn Md.</b>	
DATE REC'D BY LOCAL REG. <b>1-20-56</b>		REGISTRAR'S SIGNATURE <b>E</b>		24. FUNERAL DIRECTOR <b>Elroy D. Wilson</b>		ADDRESS <b>2004 Arden St</b>	

Kenia: Mr. Sweeney - 1981-22-56 1981-22-56

(Caution)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

204

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00218

Reg. Dist. No. ....

1. PLACE OF DEATH: 1818 Winans Avenue  
 County... Balto. County  
 City or town... Halethorpe  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 Halethorpe  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State... Md. County... Balto  
 City or town... Halethorpe  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1818 Winans Avenue  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3.(a) FULL NAME

MARY R. BRYAN

## 3.(b) Social Security Number

NONE

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED  
 6.(b) Name of husband or wife Augustus Ward  
 6.(c) If alive, give age Dec. years  
 7. Birth date of deceased (mo., day, yr.) July 10-1876

8. AGE: 79 Years Months Days It less than one day hrs. min.

9. Birthplace Loudon Co. Virginia  
 (Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

12. Name Albert Green

13. Birthplace Unknown

14. Maiden name Marion

15. Birthplace

16. Informant Shelma Barry

Address 1818 Winans Way

17. Burial Date thereof Jan. 27/56  
 (Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory National Mem. Pk.

Location Falls Church Va.

18. Funeral director Wm Cook Inc

Address 1517 th Paul st

19. Date rec'd by registrar 125/56 19 Registrar C. H. Spawen

## MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 24 1956 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1953 to 1/24 1956  
 and that I last saw him alive on 1/23 1956

Immediate cause of death Myocardial  
 Anterior Septal C.V.D.

## DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured of work?

23. SIGNATURE John C. Frey M.D.  
 Halethorpe, Md. Date signed 1/24/56



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00219  
Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Baltimore	STATE	Md. COUNTY Baltimore ✓
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN		TOWN	Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
Md. Training School for Boys		1018 William Street	
3. NAME OF DECEASED:	(First) (Middle) (Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	Lowell Franklin Chapman	1	11 19 56
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Male	White	Sing.	4/29/41
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday:	11. BIRTHPLACE (State or foreign country):
School		11 yrs.	Tenn.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:		
Letcher F. Chapman	Hazel Collins		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:	
		Mr. Letcher Chapman 117 N. Front St.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
494. Immediate cause (a)..... Idiopathic Myocardial Hypertrophy and Fibrosis DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE	CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.		DATE SIGNED
	M. D.		1/12/56
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/15/56	LaFollette	LaFollette, Tenn
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
1/12/56		JOHN F. DANNY, INC. 715 Light St.	





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 48 hours after death. After this certificate has been executed by the attending physician and properly filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

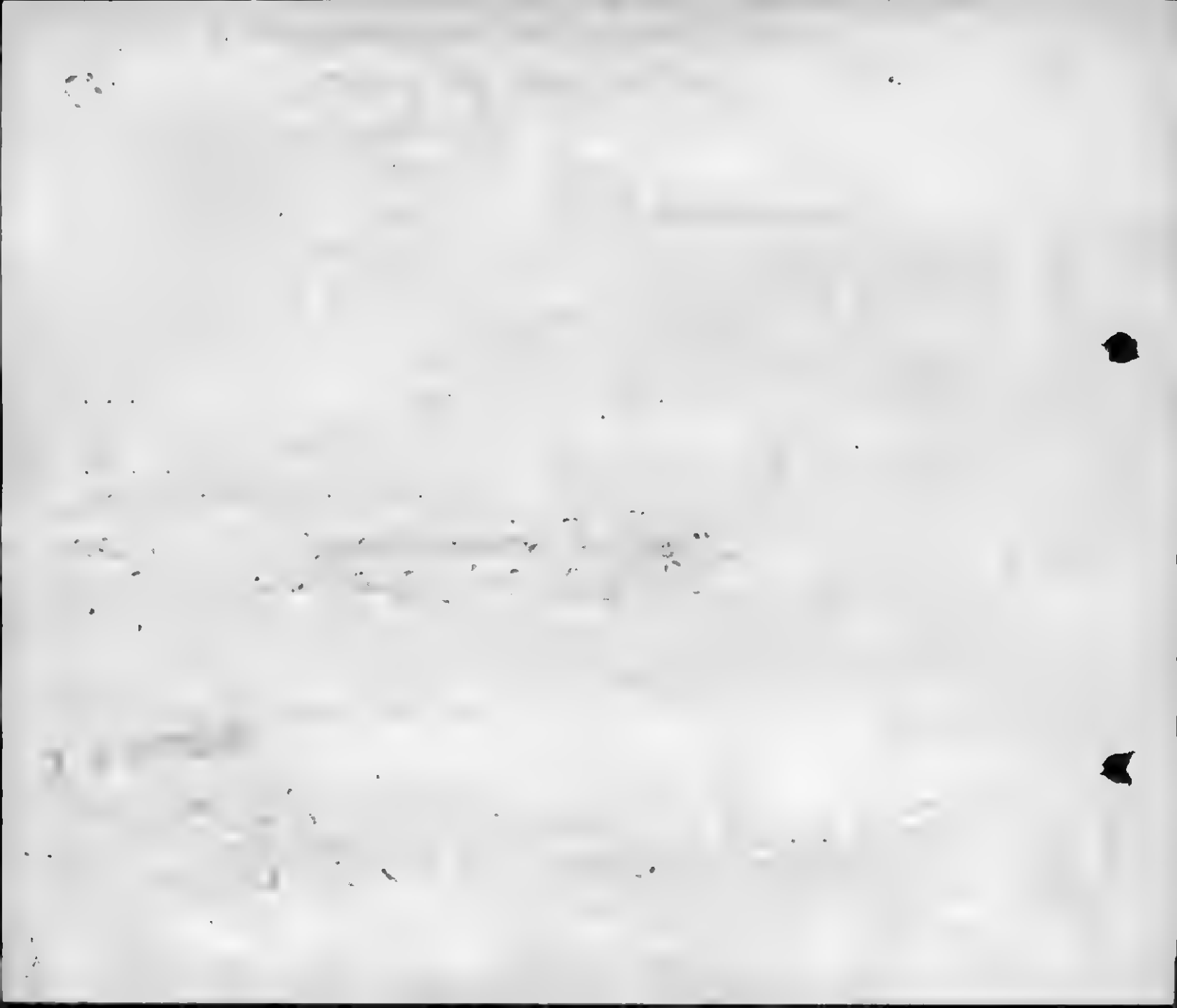
00220

234

## CERTIFICATE OF DEATH

Reg. Dist. No. 157

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Baltimore 34, Loch Raven</u>		<u>life</u>		TOWN <u>Baltimore 34, Loch Raven</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lake Drive</u>				STREET ADDRESS (If rural give location) <u>Lake Drive</u>			
<b>3. NAME OF</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>John Herbert Chenowith</u>				<u>1-7-56</u> 19 <u>56</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS</b>	
<u>male</u>	<u>white</u>	<u>married</u>	<u>4-30-1899</u>	<u>56</u> yrs.	Months Days	Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>truck driver</u>		<u>Balto. City Water Dept.</u>		<u>Maryland</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John T. Chenowith</u>				<u>Louisa Francis</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>no</u>		<u>none</u>		<u>Balto. 34, Md.</u> <u>Mrs. Mary E. Chenowith, Lake Dr.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>434.1 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u></u>				<u>1 day</u> <u>8 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiac Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Jan 2, 1956</u> to <u>Jan 8, 1956</u> that I last saw the deceased alive on <u>Jan 8, 1956</u>, and that death occurred at <u>5-30</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Walter H. Hammett</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Baltimore</u>		<b>DATE SIGNED</b> <u>1-9-56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>Burial</u>		<u>1-10-56</u>		<u>Jessops Methodist</u>		<u>Sparks, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Walter H. Hammett</u>		<u>Walter H. Hammett</u>		<u>L. Scott Brooks</u>		<u>Sparks, Md.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00221  
 CERTIFICATE OF DEATH

Reg. Dist. No. 43

235

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Essex</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Essex</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>276 Montrose Ave</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>ESTHER</u> (Middle) <u>J.</u> (Last) <u>CLARK</u>				(Month) <u>1</u> (Day) <u>4</u> (Year) <u>1956</u>			
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH: <u>6-25-1899</u>	9. AGE last birthday: <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>House-keeper at home</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Dudley Van Blarcom</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Irene Kidd (same)</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.0 Immediate cause Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last						(a) <u>acute cardiac decompensation</u> DUE TO (b) <u>arterio-sclerotic heart disease</u> DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 30, 1956</u> to <u>Jan 1, 1956</u> , that I last saw the deceased alive on <u>Jan 3, 1956</u> and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joseph M. Kidd</u> (DEGREE OR TITLE) ADDRESS <u>423 Eastern Ave</u>				DATE SIGNED <u>Jan 21, 1956</u>			
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1-9-56</u>		NAME OF CEMETERY OR CREMATORY <u>Belair Memorial</u>		LOCATION (City, town, or county) (State) <u>Belt</u> <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>1-9-56</u>		REGISTRAR'S SIGNATURE <u>Edith M. Kelley</u>		24. FUNERAL DIRECTOR: <u>John G. Connelly</u>		ADDRESS <u>Essex Md.</u>	

BUREAU V. S.

JAN 17 1

RECEIVED

236

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Ridewood</u>				OR TOWN <u>Baltimore City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Brenson Nursing Home</u>				STREET ADDRESS (If rural, give location) <u>3365 Chestnut Ave</u>			
3. NAME OF DECEASED: (First) <u>JOSEPH</u> (Middle) <u>C</u> (Last) <u>CLARK</u>		4. DATE OF DEATH: (Month) <u>1</u> (Day) <u>10</u> (Year) <u>1956</u>					
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>1-24-1877</u>	9. AGE last birthday: <u>78</u> yrs.	10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>17</u> Hours <u></u> Min. <u></u>		
11. USUAL OCCUPATION (Give kind of work done during most of working life): <u>Retired Barber Maker</u>				12. BIRTHPLACE (State or foreign country): <u>England</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
14. FATHER'S NAME: <u>James Clark</u>				15. MOTHER'S MAIDEN NAME: <u>Elizabeth Harris</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unk.)) (If Yes, give war or dates of service) <u>No</u>				17. SOCIAL SECURITY No.: <u>3365</u>			
18. INFORMANT & ADDRESS: <u>Caroline F Daniels Chestnut Ave</u>							

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>Cerebral accident (second hemorrhage)</u>		DUE TO		5 years	
Antecedent cause(s) (b) <u>Myocarditis chronic</u>		DUE TO		5 years	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Myocardial hypertrophy</u>				5 years	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>Prostate hypertrophy</u>					
19a. DATE OF OPERATION: <u>late Dec 55</u>				19b. MAJOR FINDINGS OF OPERATION: <u>Prostate removal at Sinai Hospital</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>					
21. ACCIDENT (Specify) <u>Natural</u>		PLACE (Home, farm, factory, street, or office bldg., etc.) <u>no injury</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>no injury</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>no injury</u>	
22. I hereby certify that I attended the deceased from <u>I-1-1955</u> , to <u>I-10-56</u> , 19....., that I last saw the deceased alive on <u>I-5-56</u> , 19....., and that death occurred at <u>11:50 A.M.</u> , from the causes and on the date stated above.					
SIGNATURE <u>James Graham Munster M.D.</u>		(DEGREE OR TITLE) ADDRESS <u>513 Cathedral Street</u>		DATE SIGNED <u>I-11-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1-13-56</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Ph. Parkville</u>	
LOCATION (City, town, or county) (State) <u>Md</u>					
DATE REC'D BY LOCAL REG. <u>1/12/56</u>		REGISTRAR'S SIGNATURE <u>G. C. Hedrick</u>		FUNERAL DIRECTOR <u>Frank W. Seitz 814 W 36th St. Baltimore Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



237

## CERTIFICATE OF DEATH

00223

Reg. Dist. No. 45

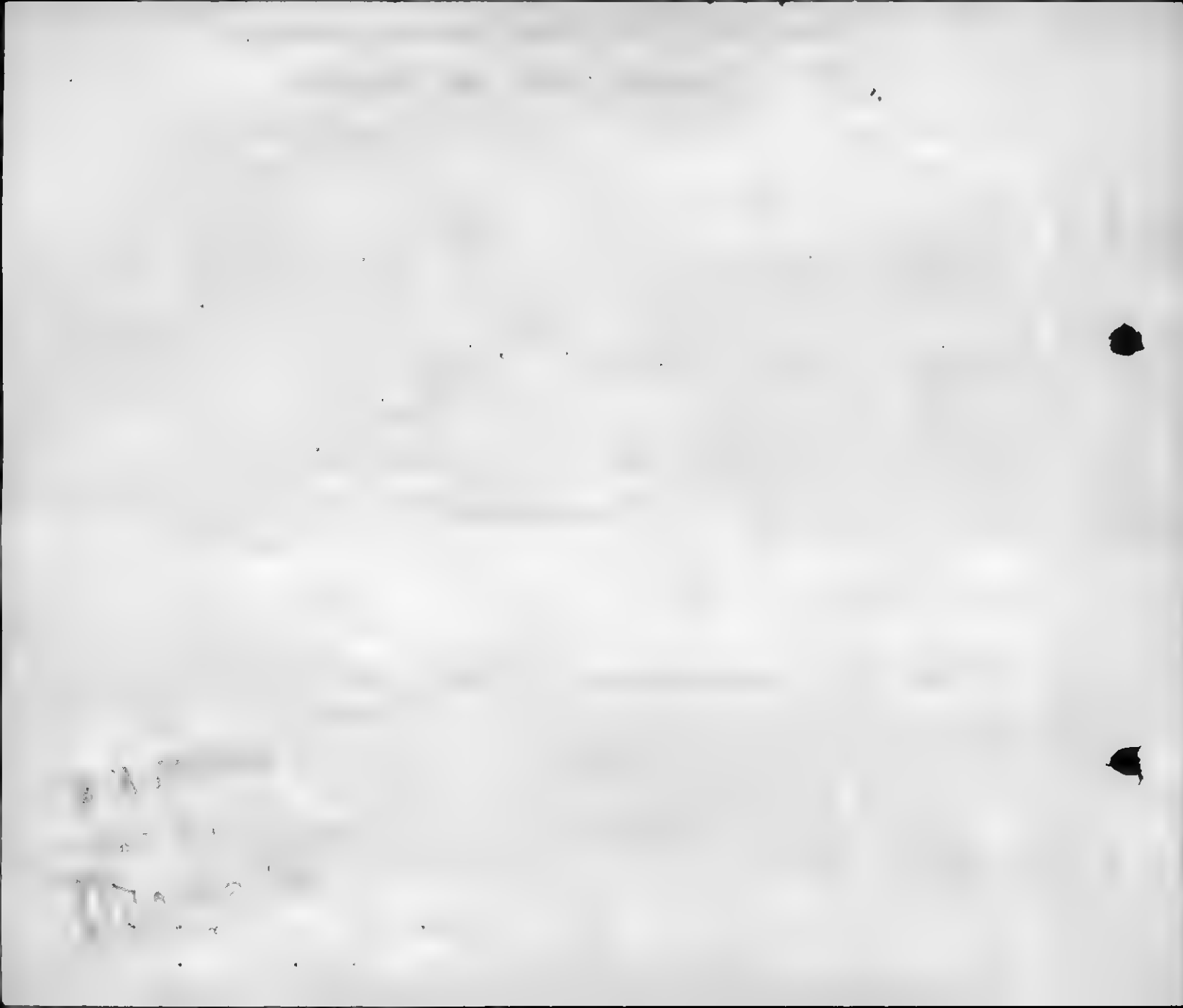
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Victory Villa				TOWN Victory Villa			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 19 E. Hickham Road				STREET ADDRESS (If rural give location) 19 E. Hickham Road			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) WANDA (Middle) RAE (Last) CLARKE				(Month) (Day) (Year) Jan. 2, 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	white	Single	May 19, 1955	Yrs. 7	Months 13	Days 13	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None				Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Lloyd Harlan Clarke				Luverna G. McGinnis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Lloyd Harlan Clarke 19 E. Hickham Road			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO (B)							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from October 1955 to Jan 2, 1956, that I last saw the deceased alive on 3/10/56, 1956, and that death occurred at 3:55 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
Edwards				M.D. 5019 Philadelphia Rd			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		Jan. 3, 1956		Pleasant Hill Cem.		Morgantown, W. Va.	
24. REG'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
JAN 4 1956		Mrs. Edith Hurley		William Cook, Inc.		1217 St. Paul Street	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M





Item 2 by phone to Augsburg Home 1-12-56 am

## CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

238

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Balto</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springthorn Hosp</u>		STREET ADDRESS (If rural, give location) <u>6811 Campfield Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Elizabeth Class</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>8</u> (Year) <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Not Known</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Not Known</u>	
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Not Known</u>	
17. INFORMANT AND ADDRESS <u>W. Katenkamp 6811 Campfield Rd</u>		12. COUNTRY OF WHAT COUNTRY <u>Not Known</u>	

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

## 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, or office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY Nov 29 55 m.INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

## 20. AUTOPSY?

Yes ☐ No ☒

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, or thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

DEGREE OR TITLE

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



239

## CERTIFICATE OF DEATH

Reg. Dist. No...

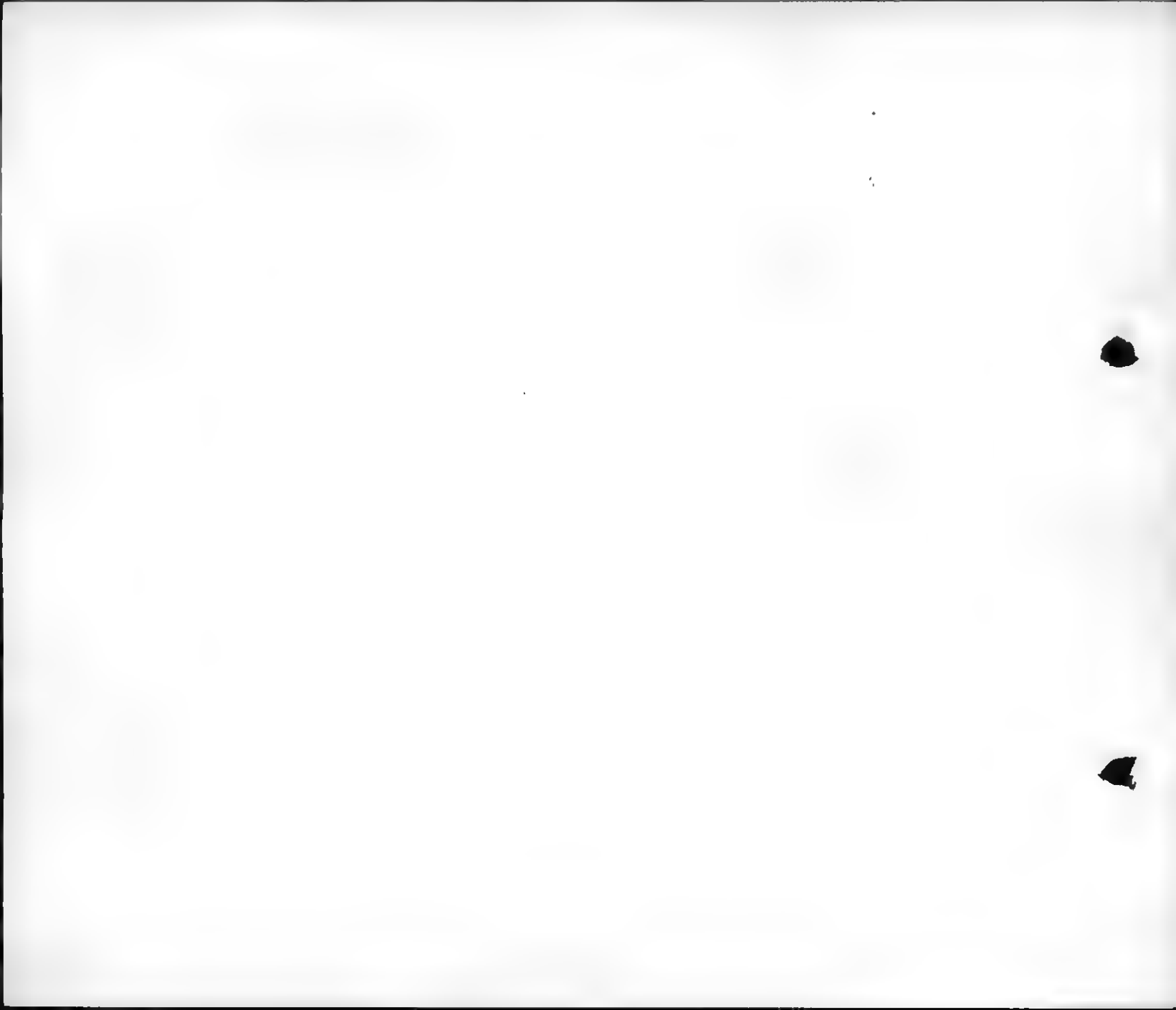
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>BALTO</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>JONES CREEK</u>	LENGTH OF STAY (in this place) <u>2 YRS</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DUNDALK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CARROLL MANOR HOME</u>		STREET ADDRESS (If rural give location) <u>34 PORTSHIP</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>ASA</u>	(Middle) <u>S.</u>	(Last) <u>COLLINS</u>	(Month) <u>JAN</u> (Day) <u>15</u> (Year) <u>1956</u>
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>JULY 5, 1867</u>
9. AGE last birthday: <u>88</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>HEATER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>STEEL CO.</u>	
11. BIRTHPLACE (State or foreign country): <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>ASA S COLLINS</u>		14. MOTHER'S MAIDEN NAME: <u>SARAH DRUITT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY No.: <u>111-50-1111</u>	
17. INFORMANT & ADDRESS: <u>MRS. ETHEL OBERLE 34 PORTSHIP</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
Immediate cause (a) <u>Arterio-sclerotic Cardio-Vascular Disease</u>		<u>11 yrs</u>
Antecedent causes (s) (b) <u>Disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Senility</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, or bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Nov. 1953, to Jan. 15, 1956, that I last saw the deceased alive on Jan. 15, 1956, and that death occurred at 9:45 PM, from the causes and on the date stated above.		
SIGNATURE <u>Dr. J. P. Davis M.D.</u>		DATE SIGNED <u>1/16/56</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>BURIAL</u>	<u>JAN 18, 1956</u>	<u>BALTIMORE</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<u>1-17-56</u>	<u>W. H. H. H.</u>	<u>ULLRICH FUNERAL HOME 4210 BELAIR.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## CERTIFICATE OF DEATH

Reg. Dist. No. 32

240

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>PIKESVILLE</u>		<u>45 yrs.</u>		TOWN <u>PIKESVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7 Waldron</u>				STREET ADDRESS (If rural give location) <u>7 WALDRON AVE.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Lydia Brading Colwill</u>				OF DEATH: <u>JAN 20 1954</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>married</u>	<u>5-28-1870</u>	<u>85 yrs.</u>	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>HOUSEWIFE</u>				<u>HOME</u>		<u>London, England</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME:			
<u>U.S.A.</u>				<u>John Milton</u>			
14. MOTHER'S MAIDEN NAME:				15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)			
<u>Elizabeth Brown</u>				<u>no</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS:			
<u>NONE</u>				<u>Edward P. Colwill, Owings Mills, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>arteriosclerotic heart disease</u>						<u>2 yrs.</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>17 Jan., 1953</u> to <u>20 Jan., 1954</u> that I last saw the deceased alive on <u>17 Jan., 1953</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul H. Rouse</u>				ADDRESS <u>Pikesville 8 md</u>		DATE SIGNED <u>20 Jan 54</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 23-56</u>		<u>David Neely</u>		<u>Pikesville 8. md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan 21, 1956</u>		<u>Northy A. Newell</u>		<u>Frank H. Newell</u>		<u>Pikesville, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE A. D. D. D. D.

1911



241

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Sparrows Point</u>		<u>25 Years</u>		TOWN <u>Sparrows Point</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 314 Route 10; Penwood Ave.</u>				STREET ADDRESS (If rural give location) <u>Box 314, Route 10, Penwood Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
(Type or Print) <u>CARL TRUMAN COOPER</u>				JAN. 30, 1956			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Feb. 2, 1905</u>	
				9. AGE last birthday: <u>50</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Analyst</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Bothlehem Steel Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Kansas</u>	
13. FATHER'S NAME: <u>Oliver W. Cooper</u>				14. MOTHER'S MAIDEN NAME: <u>Esther Hampe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: <u>213-07-9418</u>		17. INFORMANT & ADDRESS: <u>Mrs. Maisie Cooper, Box 314 Penwood Ave-19</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <u>Coronary Occlusion</u>						<u>1 hour</u>	
Antecedent causes (s) (b) <u>Coronary Arteriosclerosis &amp; I insufficiency</u>						<u>undetermined</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? <u>X</u>				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 27, 1956</u> to <u>Jan. 30, 1956</u> , that I last saw the deceased alive on <u>Jan. 27, 1956</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Daniel Owens, M.D.</u>				ADDRESS <u>914 D Street Balto. 19.</u> DATE SIGNED <u>1/31/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 2, 1956</u>		<u>Lorraine</u>		<u>Woddlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan. 31-56</u>		<u>Daniel L. Harbor</u>		<u>Ullrich Funeral Home</u>		<u>2112 Dundalk Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been examined by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

198

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

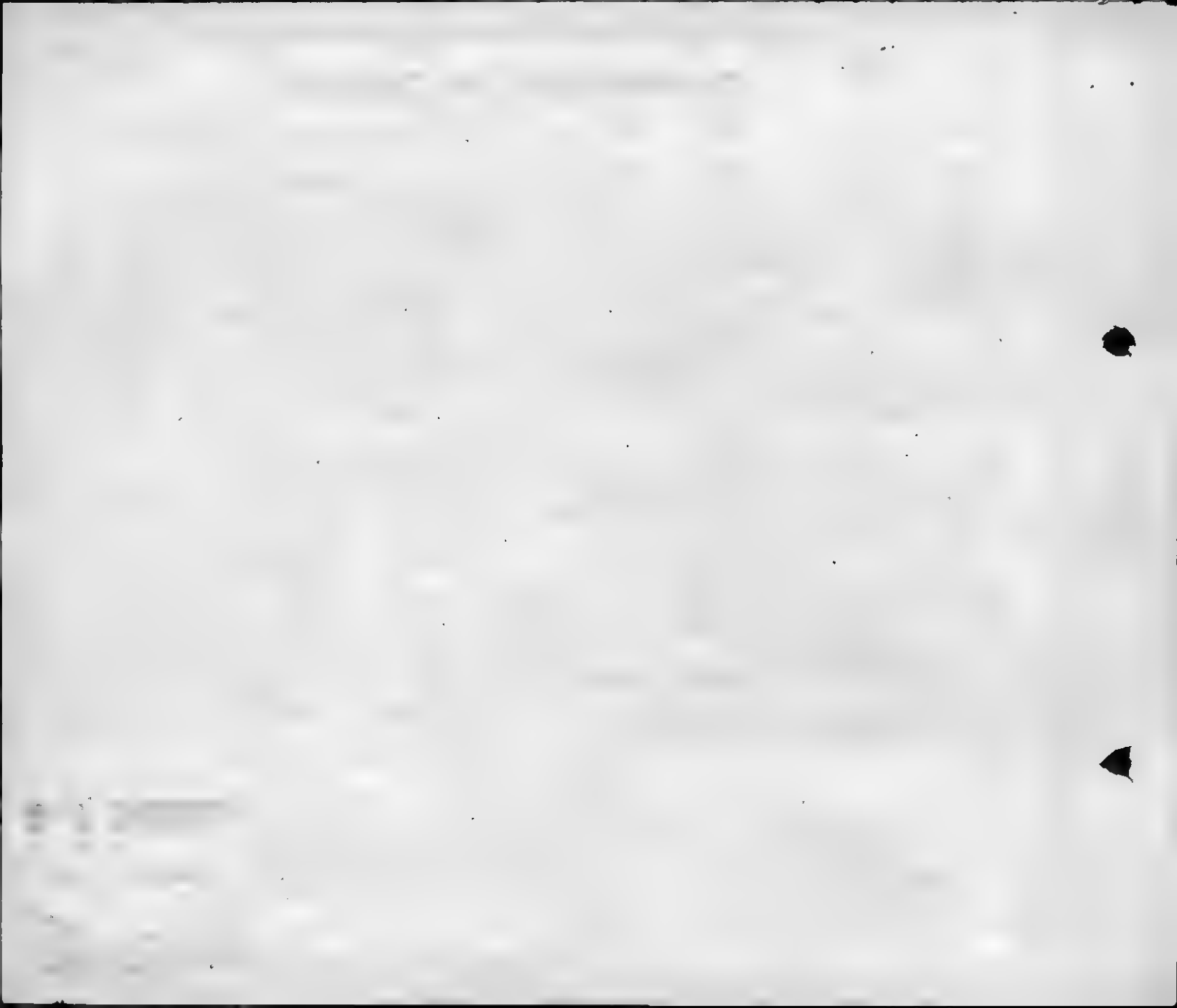
00228

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item 6, Film 21 1-26-56 et.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		STATE <u>MARYLAND</u>		STATE <u>PA</u>		COUNTY <u>ALLEGH</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>DUNDALK (22)</u>		LENGTH OF STAY (in this place) <u>5 YRS</u>		CITY (If outside corporate limits, write RURAL end give nearest town) <u>#1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8221 BULLNECK RD.</u>				STREET ADDRESS		(If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CURIE PFLAUM CULHANE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 15 1956</u>			
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>NOV. 18, 1943</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANDREW PFLAUM</u>				14. MOTHER'S MAIDEN NAME <u>TILLIE MOHR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>MRS. WM. M. SMALL - SAME</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
400.0 IMMEDIATE CAUSE (A) <u>arteriosclerotic heart disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension Cardiovascular disease</u>						3 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Rheumatoid arthritis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>53</u> , to <u>1-15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-15</u> , 19 <u>56</u> , and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Eugene F. Nevy</u>				DATE SIGNED <u>M.D. 7001 Mornington Rd Dundalk, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-14-56</u>		NAME OF CEMETERY OR CREMATORY <u>TRINITY</u>		LOCATION (City, town, or county) (State) <u>ERIE, PENNA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE				<u>Keith Bruce Bradley, Dundalk, Md.</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00229

Reg. Dist.

No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Boring</u>		LENGTH OF STAY (In this place) <u>20 yrs.</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Boring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Florence</u>		(Middle) <u>L.</u>		(Last) <u>Cullison</u>		(Month) (Day) (Year) <u>Jan. 10 1956</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>July 7, 1881</u>	
9. AGE last birthday: <u>74</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>Kinsey B. Myers</u>			
14. MOTHER'S MAIDEN NAME: <u>Mary C. Rawlings</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service) <u>no</u> <u>none</u>			
16. SOCIAL SECURITY No.: <u>212-34-1436B</u>				17. INFORMANT & ADDRESS: <u>Edgar P. Cullison, Boring, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Occlusion</u> DUE TO						<u>5 min.</u>	
Antecedent cause(s) (b) <u>Angina Pectoris</u> Diseases or conditions, if any, giving rise to the above cause DUE TO						<u>3 years</u>	
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION: <u>none</u>				19b. MAJOR FINDING OF OPERATION: <u>none</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <u>none</u>			
21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>none</u>				21c. (City or town) (County) (State) <u>none</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u> M.				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
21f. HOW DID INJURY OCCUR? <u>none</u>				22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>D. D. Caples</u>				CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. M. D. <u>Jan. 11, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Jan. 14, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		LOCATION (City, town, or county) (State) <u>Balto. Co., Maryland</u>	
DATE REC'D BY LOCAL REG. <u>1-12-56</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		24. FUNERAL DIRECTOR ADDRESS <u>Edw. C. Tipton, Hampstead, Md.</u>			

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BUREAU Y. S.

243

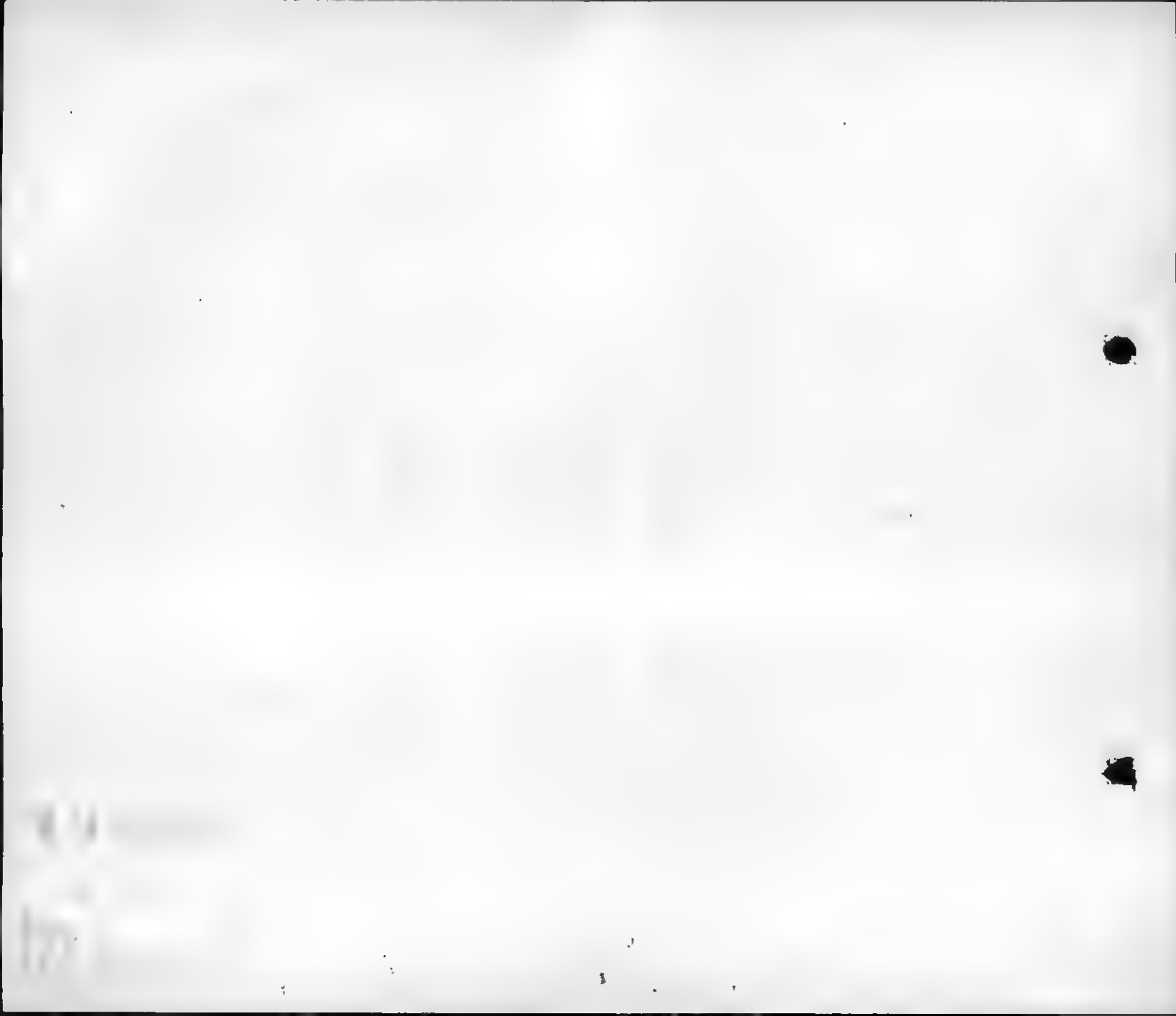
CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		OR TOWN <u>Cockeysville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York Rd.</u>				STREET ADDRESS <u>York Rd.</u>		If rural give location	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Grace Bryant Cunsey</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 12 1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Single</u>		8. DATE OF BIRTH: <u>May 22, 1907</u>	
9. AGE last birthday: <u>48</u> yrs.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>retail clothing</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Herbert R. Stevenson</u>				14. MOTHER'S MAIDEN NAME: <u>Lida Parke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>				16. SOCIAL SECURITY NO.: <u>21524-1517</u>		17. INFORMANT & ADDRESS: <u>Miss Herbert Stevenson, Cockeysville, Md.</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>170X</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Respiratory failure</u>							
DUE TO							
(B) <u>Metastatic carcinoma gen'l.</u>							
DUE TO							
(C) <u>Carcinoma Right breast</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>1748</u>				19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory or INJURY atreet, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State)				21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>54</u> to <u>Jan 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 11</u> , 19 <u>56</u> and that death occurred at <u>5:44</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Eleanor B. Sherrill</u>				DATE SIGNED <u>1/12/56</u>			
ADDRESS <u>M D Cockeysville, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>				24. FUNERAL DIRECTOR <u>Sparks, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>12 January 1956</u>				REGISTERAR'S SIGNATURE <u>Ann Armistead MacRae</u>			
				25. ADDRESS <u>L. Scott Brooks, Sparks, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

244

## CERTIFICATE OF DEATH

00231

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Home</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) <u>Algie E.</u> (Middle) <u>Louis</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>1</u> (Day) <u>20</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>M</u>	<b>8. DATE OF BIRTH</b> <u>4-9-92</u>	<b>9. AGE</b> last birthday <u>63</u> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
					Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Gen.</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Steel</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maine</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<b>13. FATHER'S NAME</b> <u>William</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. Towle</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Family - Same</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Carcinomatosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Carcinoma liver (primary)</u>				Unknown			
DUE TO (C) <u>Arteriosclerosis, generalized</u>				Unknown			
<b>19. DATE OF OPERATION</b> <u>1955</u>				<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>Carcinomatosis - abdominal cavity</u>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>1-20</u> , 19 <u>56</u> , to <u>1-20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-20</u> , 19 <u>56</u> , and that death occurred at <u>10:30</u> A.M. from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Stephen L. Hapness</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Crownville 29 Md</u>		<b>DATE SIGNED</b> <u>1-20-56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b> <u>1-23-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Good Hope</u>		<b>LOCATION</b> (City, town, or county) <u>Baltimore</u> (State)	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>W. E. Hapness</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. E. Hapness</u>		<b>ADDRESS</b> <u>Paradise Home</u>	

HONORABLE A. E.

1884



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00232  
245 CERTIFICATE OF DEATH Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Balto.</b>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Catonsville</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Catonsville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>5743 Edmondson Ave.</b>		STREET ADDRESS (If rural give location) <b>5743 Edmondson Ave.</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>GRACE M. DAVIS</b>		4. DATE (Month) (Day) (Year) OF DEATH <b>Jan. 4, 1956</b>	
5. SEX: <b>female</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>single</b>	8. DATE OF BIRTH: <b>June 1, 1889</b>
9. AGE last birthday <b>66</b> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>at home</b>	
11. BIRTHPLACE (State or foreign country): <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Wm. T. Davis</b>		14. MOTHER'S MAIDEN NAME: <b>Sarah Haines</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>no</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT & ADDRESS: <b>Lantheum, Md. Mr. Joseph S. Davis, Sr. 418 Forest View Rd</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Cerebral vascular Accident</b>			<b>18 hrs.</b>
ANTECEDENT CAUSE (B) <b>Hypertensive Cardiovascular Disease</b>			<b>2 yrs.</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Dec 27, 1953</b> to <b>Jan 4, 1956</b> , that I last saw the deceased alive on <b>Jan 3, 1956</b> , and that death occurred at <b>4:30 A. M.</b> from the causes and on the date stated above.			
SIGNATURE <b>J. McKee</b>		ADDRESS <b>M. D. 6014 Brandon Ave.</b>	
DATE SIGNED <b>1/4/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1/6/56</b>	
NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Jan 5, 1956</b>		REGISTRAR'S SIGNATURE <b>Car. Federal</b>	
24. FUNERAL DIRECTOR <b>Am. J. Dickner &amp; Sons - Balto</b>		ADDRESS <b>17 Md</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01401  
1440 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MT Wilson</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MT Wilson State Hospital</u>	MARYLAND LENGTH OF STAY (In this place) <u>2 days</u>	STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural, give location) <u>Old Washington Blvd. and Sterwood Road</u>	
3. NAME OF DECEASED: (Type or Print) <u>Raymond</u> (First) (Middle) (Last) <u>Davis</u>		4. DATE OF DEATH: <u>1-28-1956</u> (Month) (Day) (Year)	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>2-2-1904</u> (Month) (Day) (Year)
9. AGE last birthday <u>51</u> yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Carpentry</u>	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George Thomas Davis</u>		14. MOTHER'S MAIDEN NAME: <u>Carrie Kinney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>2</u>	
17. INFORMANT'S ADDRESS: <u>Waynard Davis, Box 213 B, Edbridge Md</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>		<u>?</u>	
ANTECEDENT CAUSE (B):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-27-1956</u> , to <u>1-28-1956</u> , that I last saw the deceased alive on <u>1-28-1956</u> , and that death occurred at <u>2 P. M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>William Newman</u>		ADDRESS <u>M. D. Mount Wilson Maryland</u>	
DATE SIGNED <u>1-28-56</u>			
23. BURIAL, CREMATION, REMOVAL, OR PREPARATION		DATE THEREOF <u>1/31/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Union Fd. Med. School</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>FEB 15</u>		REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	
24. FUNERAL DIRECTOR		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 16 1904

BUREAU V. S.

CERTIFICATE OF DEATH

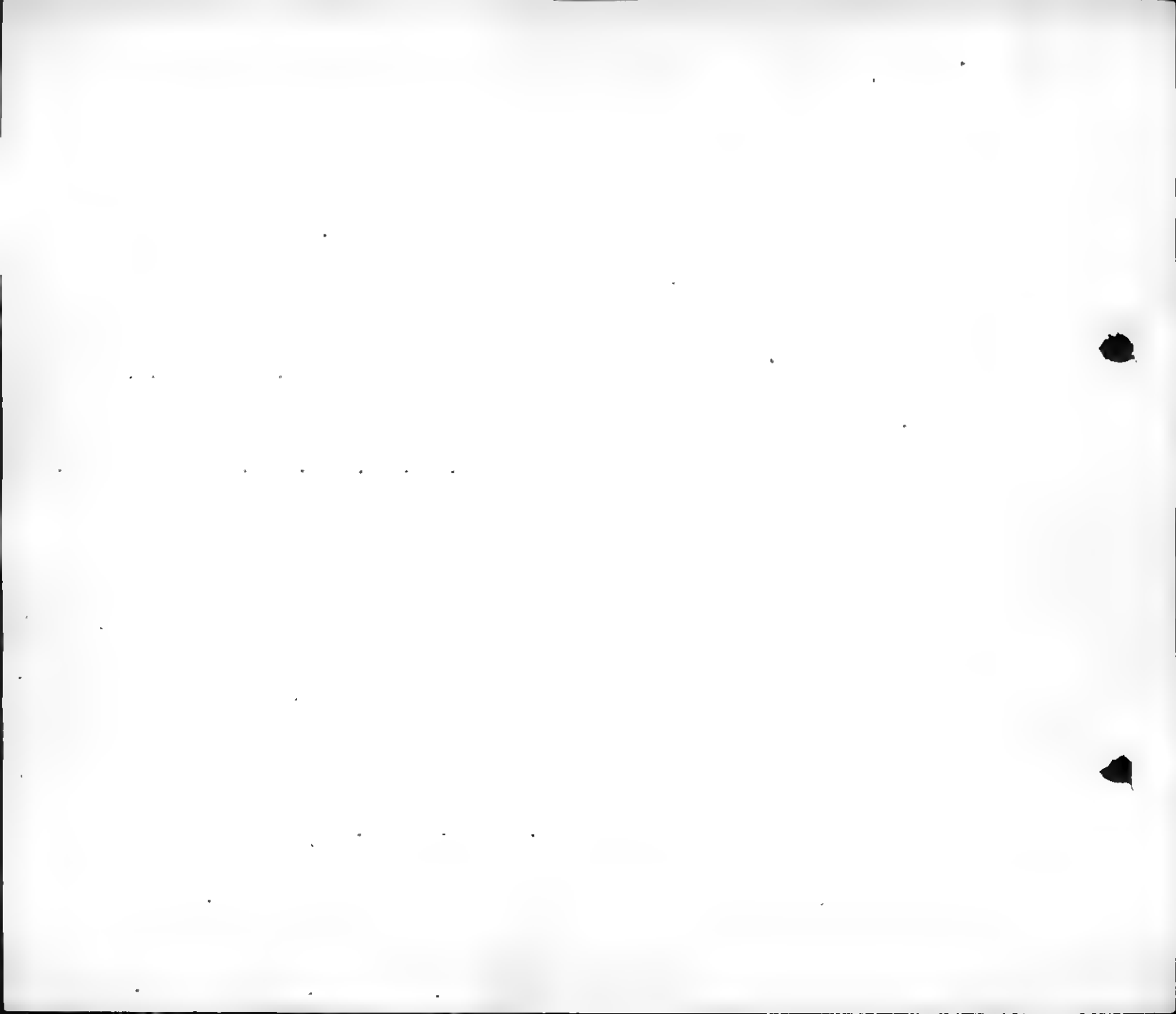
Reg. Dist. No. ...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>	LENGTH OF STAY (in this place) <u>28 Days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>3111 N. Charles Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JAMES F. DEANE (ALSO: DEAN)</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>January 28 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>11/12/73</u>
9. AGE last birthday <u>82</u> yrs		10. UNDER 1 YEAR Months Days	11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>East New Market, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Frank H. Deane</u>	
14. MOTHER'S MAIDEN NAME: <u>Emma Vane</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Yes</u> <u>OW</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE <u>MASSIVE GASTROINTESTINAL HEMORRHAGE</u>			<u>UNKNOWN</u>
(B) ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>MULTIPLE GASTRIC ULCERATIONS</u>			<u>UNKNOWN</u>
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>DIABETES MELLITUS</u> <u>BENIGN PROSTATIC HYPERTROPHY</u>			<u>1 YEAR</u> <u>1 YEAR</u>
19A. DATE OF OPERATION: <u>1/23/56</u>		19B. MAJOR FINDINGS OF OPERATION <u>SUPRAPUBIC PROSTATOCYSTOTOMY</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 31, 1955, to Jan. 28, 1956, that I last saw the deceased <u>alive</u> and that death occurred at 6:50 PM, from the causes and on the date stated above.			
SIGNATURE <u>DONALD D. MARK</u>		DATE SIGNED <u>Jan 31, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-31-56</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedridge</u>	
24. FUNERAL DIRECTOR <u>Stewart &amp; Mowen Funeral Home</u>		ADDRESS <u>108 W. North Ave. Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

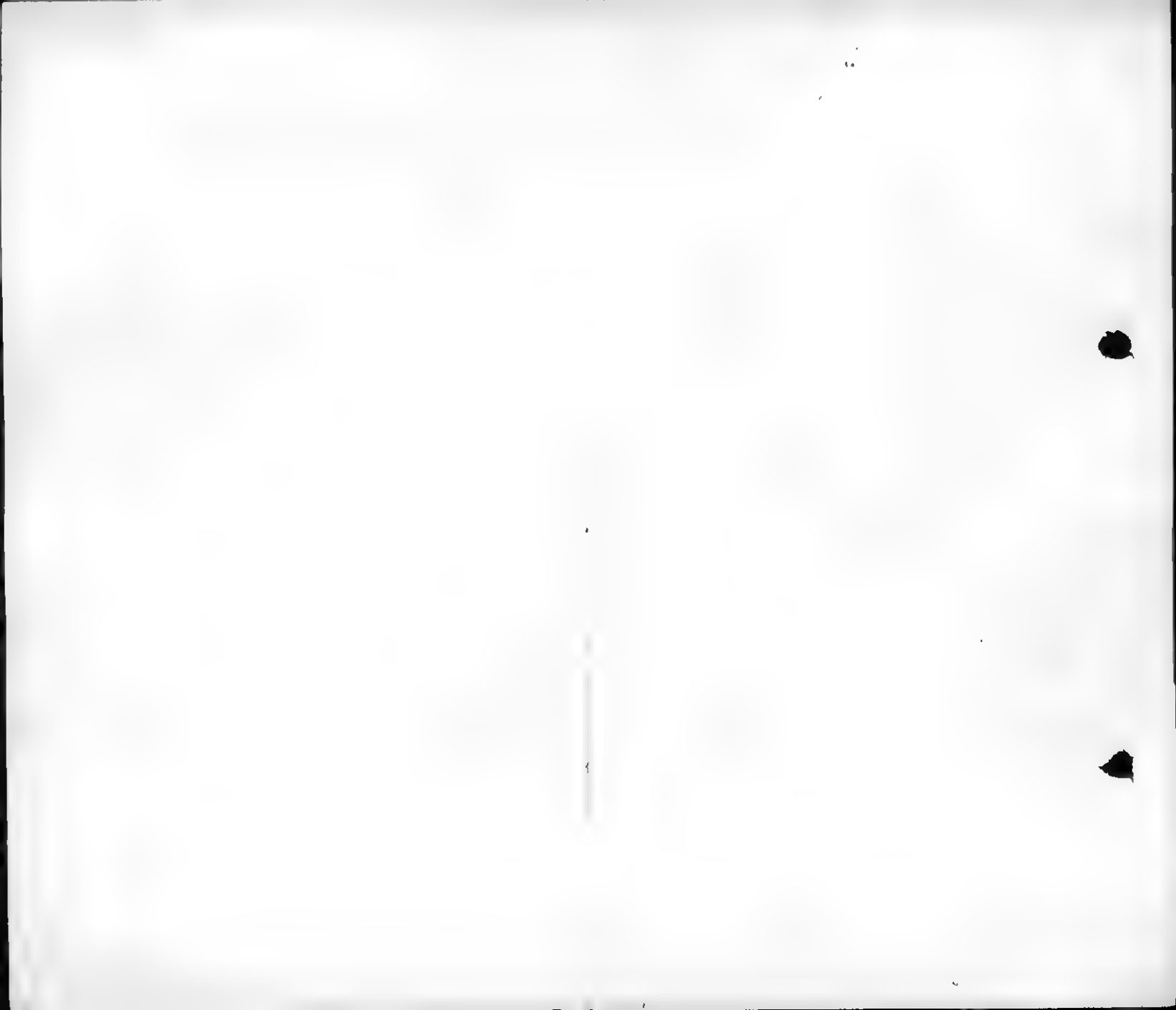
247

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00234

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Balto.</u> MARYLAND	STATE <u>md.</u> COUNTY <u>Balto.</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		
TOWN <u>35 yrs.</u>	TOWN		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7 Madeline Ave</u>	STREET ADDRESS (If rural give location) <u>7 Madeline Ave</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Barbara M. Decker</u>		<u>Jan 15 1956</u>	
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Sept 15 1879</u>
		9. AGE last birthday: <u>76</u> yrs	10. MONTHS: <u>76</u> Months
		11. BIRTHPLACE (State or foreign country): <u>Balto. Co.</u>	12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>At Home</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Housework</u>	
13. FATHER'S NAME: <u>Andrew Redel</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Raab</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <u>215-09-0495</u>	
17. INFORMANT & ADDRESS: <u>Margaret M. Sherman 7 Madeline Ave</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>10 yrs.</u>	
IMMEDIATE CAUSE (A) DUE TO			
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While at work Not while at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec. 11, 1947</u> to <u>Jan. 15, 1956</u> that I last saw the deceased alive on <u>Jan. 11, 1956</u> , and that death occurred at <u>1:05 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Adam G. Swin</u>		ADDRESS <u>6232 Belair Road</u>	
DATE SIGNED <u>Jan. 16, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>BURIAL</u>		<u>JAN 18, 56</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>HOLY REDEEMER</u>		<u>BELAIR RD MD</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>JAN - 56</u>		<u>Duffel Bros 7110 BELAIR RD</u>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00235  
248  
CERTIFICATE OF DEATH

Reg. Dist. No. 36

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Towson</u>		TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>105 Ware Avenue</u>		<u>105 Ware Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>AUGUST C. DEICHELHANN</u>		<u>January 2, 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widower</u>	8. DATE OF BIRTH: <u>December 3, 1872</u>
9. AGE last birthday: <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Self employed</u>	
11. BIRTHPLACE (State or foreign country): <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Arnold Detchelmann</u>		14. MOTHER'S MAIDEN NAME: <u>Rosina Messler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Thomas Hawkins, Balto., Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>3 YRS.</u>	
(A) IMMEDIATE CAUSE <u>CARCINOMA OF PROSTATE</u>			
(B) ANTECEDENT CAUSE (S) <u>DUE TO</u>			
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
2. I hereby certify that I attended the deceased from <u>Dec. 31, 1955</u> , to <u>Jan. 2, 1956</u> , that I last saw the deceased alive on <u>Dec. 31, 1955</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>William G. Brubaker</u>		ADDRESS <u>Towson</u>	
DATE SIGNED <u>1/5/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 6, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		LOCATION (Cty., town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 5, 1956</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	
MUNICIPAL DIRECTOR <u>John Burns</u>		ADDRESS <u>Towson, Maryland</u>	

3. 10. 1962

10. 10. 1962

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

00236

Reg. Dist. No. ....

Item 13, Film 92 2-21-56 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1805 Selma Ave</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>1805 Selma Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>GERALD</u> (First) <u>MICHAEL</u> (Middle) <u>DELIHANT</u> (Last)		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>31</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 31 1905</u>
9. AGE last birthday <u>50</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Delihant</u>		14. MOTHER'S M maiden name <u>Fitzgual</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>215-09-0992</u>	
17. INFORMANT <u>Lillian Delihant (wife)</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>Acute Colitis &amp; Cerebral embolus</u>		<u>3 da</u>
Antecedent cause(s) <u>Chronic myocarditis</u>		<u>1 yr</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Chronic myocarditis</u>		<u>5 1/2 yrs</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cerebral embolus</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 13, 1956 to Jan 31, 1956, that I last saw the deceased alive on Jan 31, 1956 and that death occurred at 5:35 m., from the causes and on the date stated above.

SIGNATURE D. B. Brumbaugh (Degree or title) ADDRESS 539 Main St Elkridge 27 Md DATE SIGNED Feb 2 1956

23. BURIAL, CREMATION, REMOVAL (Specify) Buried DATE THEREOF Feb 3 56 NAME OF CEMETERY OR CREMATORY Greenwood LOCATION (City, town, or county) Frederick, Md (State) Md

DATE REC'D BY LOCAL REG. Feb 2 56 REGISTRAR'S SIGNATURE Har Keiffer 24. FUNERAL DIRECTOR ADDRESS 1746 Carroll Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

1956

111

249

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto. Co.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Sorenson Nursing Home</u> <u>7912 Ruxway Rd.</u>		STREET ADDRESS (If rural give location) <u>711 Morningside Drive</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan.</u> <u>15,</u> 19 <u>56</u>			
<u>LOUISA G. DEPKIN</u>							
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>July 4, 1863</u>	9. AGE last birthday: <u>92</u> yrs.	IF UNDER 1 YEAR: Months <u>0</u> Days <u>10</u> Hours <u>10</u> Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at Home</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Herman Gohlinghorst</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Drive, Towson, Md.</u> <u>Mrs. Dorothea G. White-711 Morningside</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>acute</u>				INTERVAL BETWEEN ONSET AND DEATH: <u>5 yrs</u>			
ANTECEDENT CAUSE (B) <u>hypertrophy myocardial</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Congestion of lungs</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>advanced age.</u>							
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION: <u>no operation</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>home</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>no injury</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>1956</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>fall</u>			
22. I hereby certify that I attended the deceased from <u>Nov 6-</u> , 19 <u>55</u> , to <u>1-15-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-11-</u> , 19 <u>56</u> , and that death occurred at <u>10M</u> , from the causes and on the date stated above.							
SIGNATURE: <u>Garnes Graham Manton.</u>		M.D. <u>510 Catherine St. Balt. Md.</u>		DATE SIGNED: <u>Jan</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF: <u>1/18/56</u>		NAME OF CEMETERY OR CREMATORY: <u>Loudon Park Cem.</u>		LOCATION (City, town, or county) (State): <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>1-18-56</u>		REGISTRAR'S SIGNATURE: <u>[Signature]</u>		24. FUNERAL DIRECTOR: <u>[Signature]</u>		ADDRESS: <u>Balto 17 Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



250

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

8379

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Prince George</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonville</u>	LENGTH OF STAY (in this place) <u>6 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Washington (Pine Grove)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hosp</u>		STREET ADDRESS (If rural give location) <u>6668 Walkersmill Rd.</u>	
3. NAME OF DECEASED: (First) <u>Bessie</u> (Middle) <u>May</u> (Last) <u>Dickey</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>10</u> , 19 <u>56</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>9-20-1887</u>
		9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life) <u>Book Keeper, own Feed business</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Roy Houck</u>		14. MOTHER'S MAIDEN NAME: <u>Emma Lamb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FC. SER. (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hosp</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>			
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Cardiovascular disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Brain Syndrome assoc. w/ cerebral arteriosclerosis</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) (Min.) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/4/1</u> , 19 <u>56</u> to <u>1/10/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/10/1</u> , 19 <u>56</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Stella Wachter</u>		DATE SIGNED <u>1/11/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/13/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Switzland Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/18/56</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	
24. FUNERAL DIRECTOR <u>F. Sucke Sons</u>		ADDRESS <u>Hyattsville Md.</u>	

BUREAU V. S.

JAN 19 1956

RECEIVED



251

## CERTIFICATE OF DEATH

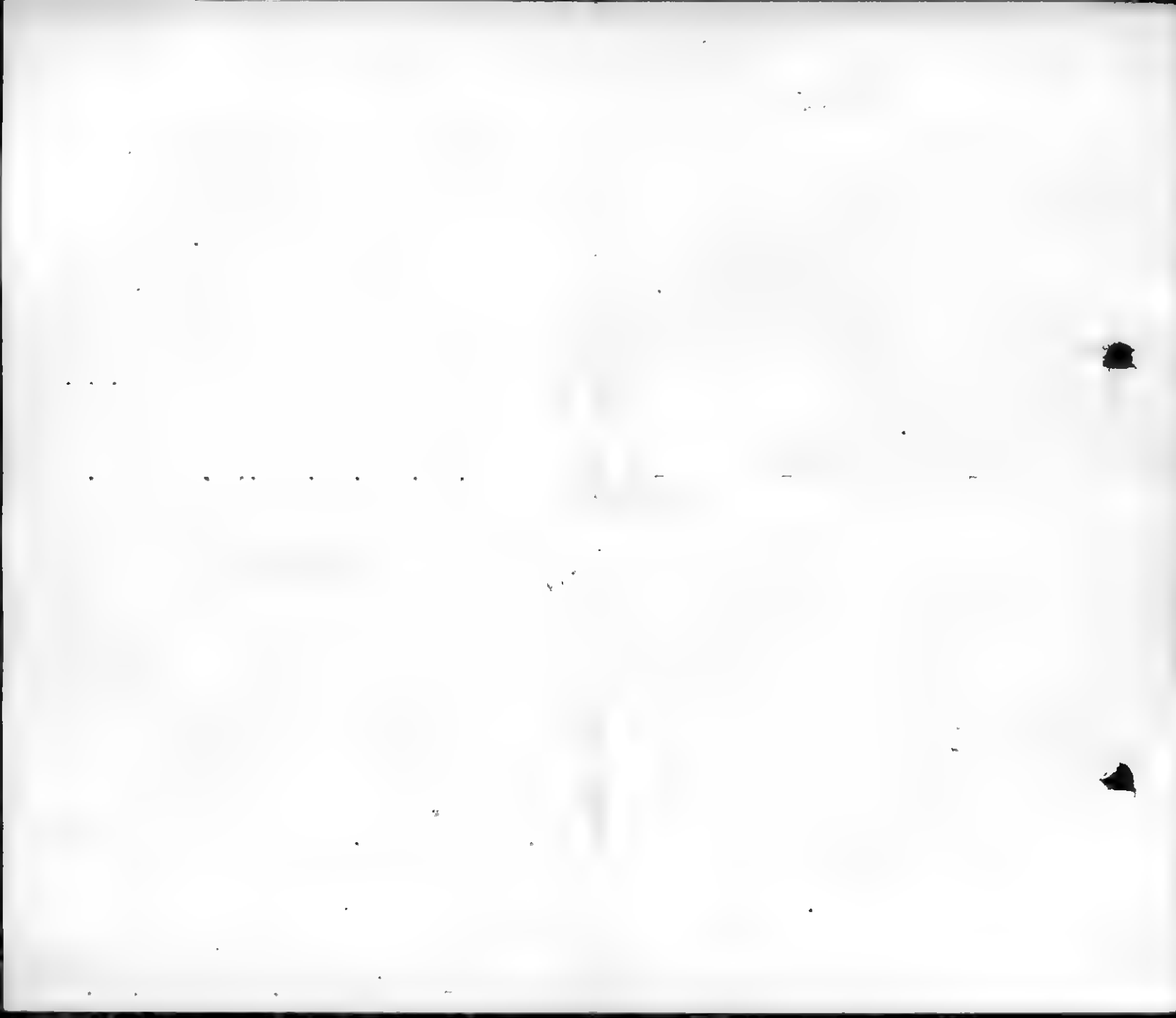
Reg. Dist. No. *XX*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>BALTIMORE</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>FORT HOWARD</b>		<b>16 Days</b>		TOWN <b>BALTIMORE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>1610 DRUID HILL AVENUE</b>			
3. NAME OF DECEASED: (Type or Print)		(First) <b>RALPH</b>		(Middle) <b>F.</b>		(Last) <b>DIXON</b>	
4. DATE OF DEATH		(Month) <b>JANUARY</b>		(Day) <b>15,</b>		(Year) <b>1956</b>	
5. SEX: <b>MALE</b>	6. COLOR OR RACE: <b>COLORED</b>	7. SINGLE <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>	8. DATE OF BIRTH: <b>April 19, 1898</b>		9. AGE last birthday: <b>57</b> yrs	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Automobile Business</b>		11. BIRTHPLACE (State or foreign country): <b>Philadelphia, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Ralph F. Dixon</b>				14. MOTHER'S MAIDEN NAME: <b>Bertha Brown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give year or dates of service) <b>Yes</b> <input checked="" type="checkbox"/> <b>WW-1</b>		16. SOCIAL SECURITY NO. <b>217-03-2320</b>		17. INFORMANT & ADDRESS: <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Unknown	
IMMEDIATE CAUSE (A) <b>CARCINOMA OF PROSTATE WITH METASTASIS TO RECTUM, SEMINAL VESICULE AND LUNGS</b>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>1-12-56</b>		19B. MAJOR FINDINGS OF OPERATION: <b>TRANSRECTAL BIOPSY</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify, that I attended the deceased from <b>Dec. 30, 1955, to Jan. 15, 1956</b> , and that death occurred at <b>10:15 AM</b> , from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>		ADDRESS <b>M. D. Fort Howard, Maryland</b>		DATE SIGNED <b>1-15-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1/19/56</b>		NAME OF CEMETERY OR CREMATION <b>Baltimore National</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
DATE RECD BY LOCAL REGISTRAR <b>1-16-56</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		ADDRESS <b>Charles R. San Funeral Home 802-04 Madison Ave., Baltimore, Md.</b>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate must be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

252

## CERTIFICATE OF DEATH

00240

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>BALTIMORE</b>		STATE <b>MARYLAND</b>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>FORT HOWARD</b>		<b>14 DAYS</b>		TOWN <b>BALTIMORE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>2018 SWANSEA ROAD</b>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<b>CHARLES R. DONNELLY</b>				<b>JANUARY 16 1956</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
<b>MALE</b>	<b>WHITE</b>	<b>MARRIED</b>	<b>September 8, 1888</b>	<b>67</b>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Fireman</b>		<b>City</b>		<b>New York, N. Y.</b>		<b>U. S. A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>James Donnelly</b>				<b>Mary MN: Holmes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>Yes</b> <b>WW I</b>		<b>219-05-1863</b>		<b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<b>12 HOURS</b>	
IMMEDIATE CAUSE (A) <b>PULMONARY EMBOLUS</b>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDIT ON CAUSING DEATH.						<b>4 Months</b>	
						<b>7 Years</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<b>1/10/56</b>		<b>Transurethral resection</b>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED White at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan. 2</b> , 19 <b>56</b> , to <b>Jan. 16</b> , 19 <b>56</b> , and that death occurred at <b>10:20 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>M. D. Joseph M. Miller</b>				ADDRESS (Street, city, town, state) <b>VAH FORT HOWARD, MARYLAND</b>			
DATE SIGNED <b>1-17-56</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>1-20-56</b>		<b>New Cathedral Cemetery</b>		<b>Baltimore, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<b>Jan. 20, 1956</b>		<b>Lawson L. Lister</b>		<b>Wm. Cook-Blight, Inc.</b>		<b>6009 Harford Rd., Balto. Md.</b>	

1920

1921

1922

253

## CERTIFICATE OF DEATH

Reg. Dist. No. . . . .

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u> MARYLAND			STATE <u>Maryland</u> COUNTY		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>			STREET ADDRESS (If rural give location) <u>Bayview Hospital - Bayview, Md.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Hannah</u> <u>Dubin</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 26</u> <u>1956</u>		
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>unknown</u>		
9. AGE last birthday <u>73</u> yrs.			10. IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>			10B. KIND OF BUSINESS OR INDUSTRY:		
11. BIRTHPLACE (State or foreign country): <u>Russia</u>			12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>		
13. FATHER'S NAME: <u>Moses Dubin</u>			14. MOTHER'S MAIDEN NAME: <u>Jennie Yeffe</u>		
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>unknown</u>		
17. INFORMANT & ADDRESS: <u>Records of Spring Grove State Hosp.</u>			18. MEDICAL CERTIFICATION		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (A) <u>Cardio-vascular accident</u>					
ANTECEDENT CAUSE (S) (B) <u>Generalized arteriosclerosis</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes Mellitus</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>July</u> , 1953, to <u>Jan. 26</u> , 1956 that I last saw the deceased alive on <u>Jan. 26</u> , 1956, and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>Gulla Warshler</u>			DATE SIGNED <u>Jan. 26, 1956</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>unburied</u>			24. FUNERAL DIRECTOR ADDRESS		
DATE REC'D BY LOCAL REGISTRAR <u>FEB 15 1956</u>			REGISTERAR'S SIGNATURE <u>T. E. Harry</u>		

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 16 1956

BUREAU V. S.

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00241

254  
CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>B</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
TOWN				STREET ADDRESS (If rural give location) <u>2692 ST. BENEDICT ST.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgway Manor Nursing Home</u>							
3. NAME OF DECEASED (Type or Print) <u>Joseph Richard Edler</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 16, 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Aug 4 1917</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAYOUT MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MILLWORK</u>		9. AGE last birthday <u>38</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Joseph Edler</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-01-8733A</u>		17. INFORMANT & ADDRESS <u>Joseph H. Edler 3140 WILKENO AVE</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				<u>7 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio Vascular Disease</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 8, 1956</u> to <u>Jan 16, 1956</u> , that I last saw the deceased alive on <u>Jan 16, 1956</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above. <u>Jan 17, 1956</u>							
SIGNATURE <u>George R. Schwab</u> M.D.				ADDRESS (Street, city, town, state) <u>2101 Frederick Ave Baltimore, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4-20-56</u>		NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>	
24. REC'D BY REGISTRAR <u>V. E. Harris</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>George R. Schwab</u>		ADDRESS <u>2101 Frederick Ave</u>	
DATE <u>Jan 18, 1956</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN ON HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1 55 10M





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

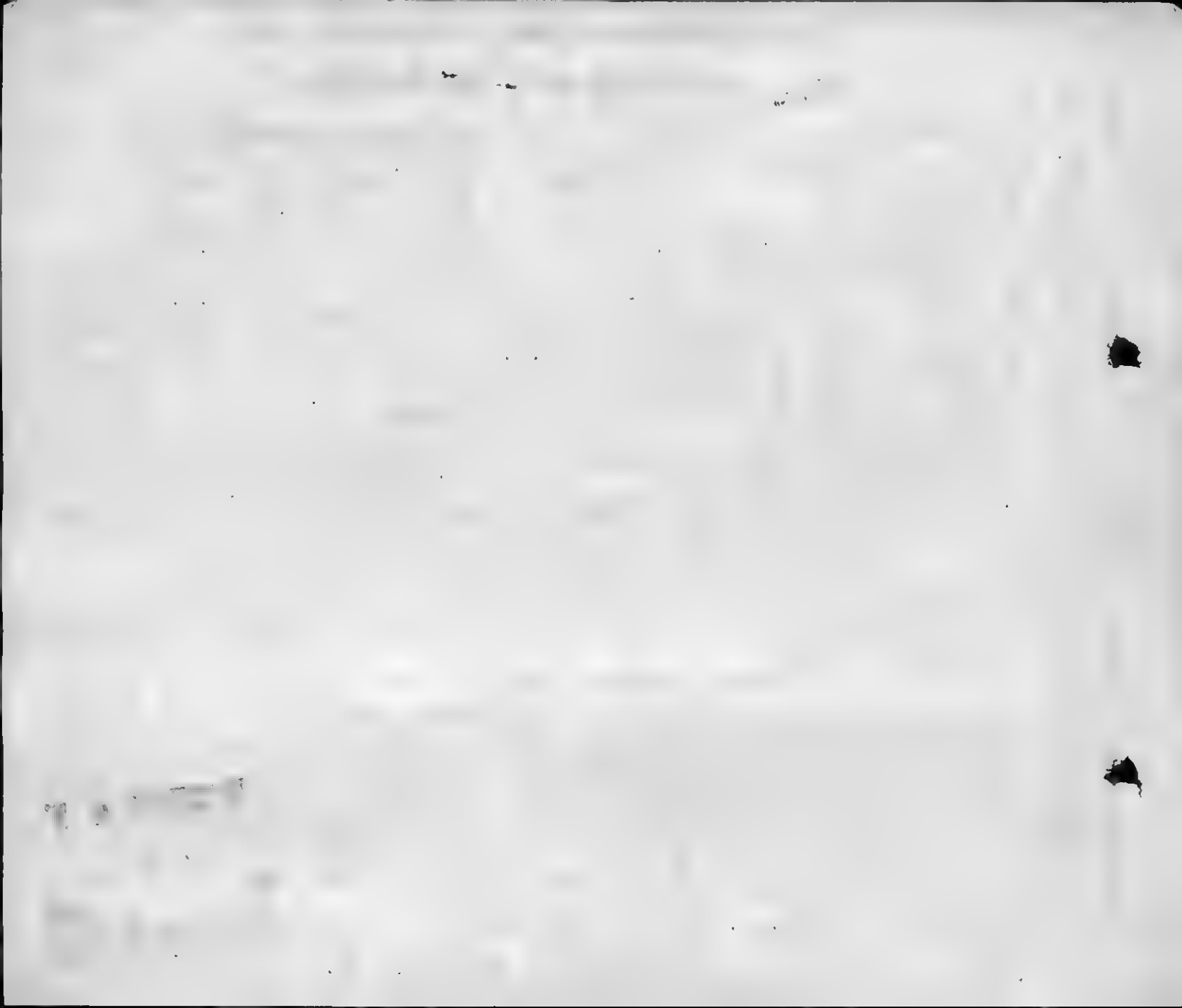
00242

255

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>M Essex - 24</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7308 Kirtley Rd.</u>				STREET ADDRESS <u>7308 Kirtley Rd.</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>ANNA</u>		(Middle) <u>- -</u>		(Last) <u>ELGERT</u>		(Month) (Day) (Year) <u>Jan. 9. 1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov. 6. 1913</u>	9. AGE last birthday <u>42</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Bauers</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Biggerman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S ADDRESS <u>Mr. Arthur R. Elgert (Husband) 7308 Kirtley Rd. - 24</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Acute myocardial infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic coronary artery disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic coronary artery disease</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>12-24-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>See (C) above</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <u>at work</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Baltimore Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>M. 11:00 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Heart attack</u>			
22. I hereby certify that I attended the deceased from <u>Jan. 9. 1956</u> to <u>Jan. 9. 1956</u> , that I last saw the deceased alive on <u>Jan. 9. 1956</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>D. B. Bronush, M.D.</u>				ADDRESS (Street, city, town, state) <u>Baltimore Md.</u>		DATE SIGNED <u>Jan. 13. 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 13. 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore County Md.</u>	
24. REC'D BY REGISTRAR <u>H. J. Smith</u>		REGISTRAR'S SIGNATURE <u>Mrs. Edith Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER &amp; SONS, INC.</u>		ADDRESS <u>Baltimore Md.</u>	



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00243

## 255 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Md.</u> COUNTY <u>Baltimore</u>		CITY <u>Oella</u>		CITY <u>Oella</u>	
(If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place) <u>15 yrs</u>		(If outside corporate limits, write RURAL and give nearest town)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rock Springs, Ellicott City</u>		STREET ADDRESS (if rural give location) <u>Rock Springs, Ellicott City</u>					
3. NAME OF DECEASED (Type or Print) <u>Lee Ellis</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 6 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 25, 1879</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Electrician,</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>76</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
13. FATHER'S NAME <u>John Ellis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Sherwood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Rose Ellis, Rock Springs,</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>Ellicott City, Md.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>	
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardio Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/82</u> , 19 <u>55</u> , to <u>1/6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/6</u> , 19 <u>56</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George D. Bunting</u>		M.D. <u>Church St. ELlicott City, Md.</u>		ADDRESS (Street, city, town, state) <u>1/6/56</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE WHEREOF <u>Jan. 9/56</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		LOCATION (City, town, or county) (State) <u>Woodlawn 7, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzke</u>		ADDRESS <u>4101 E dmondsch Ave</u>	
DATE <u>Jan. 9, 1956</u>							

10-11-50

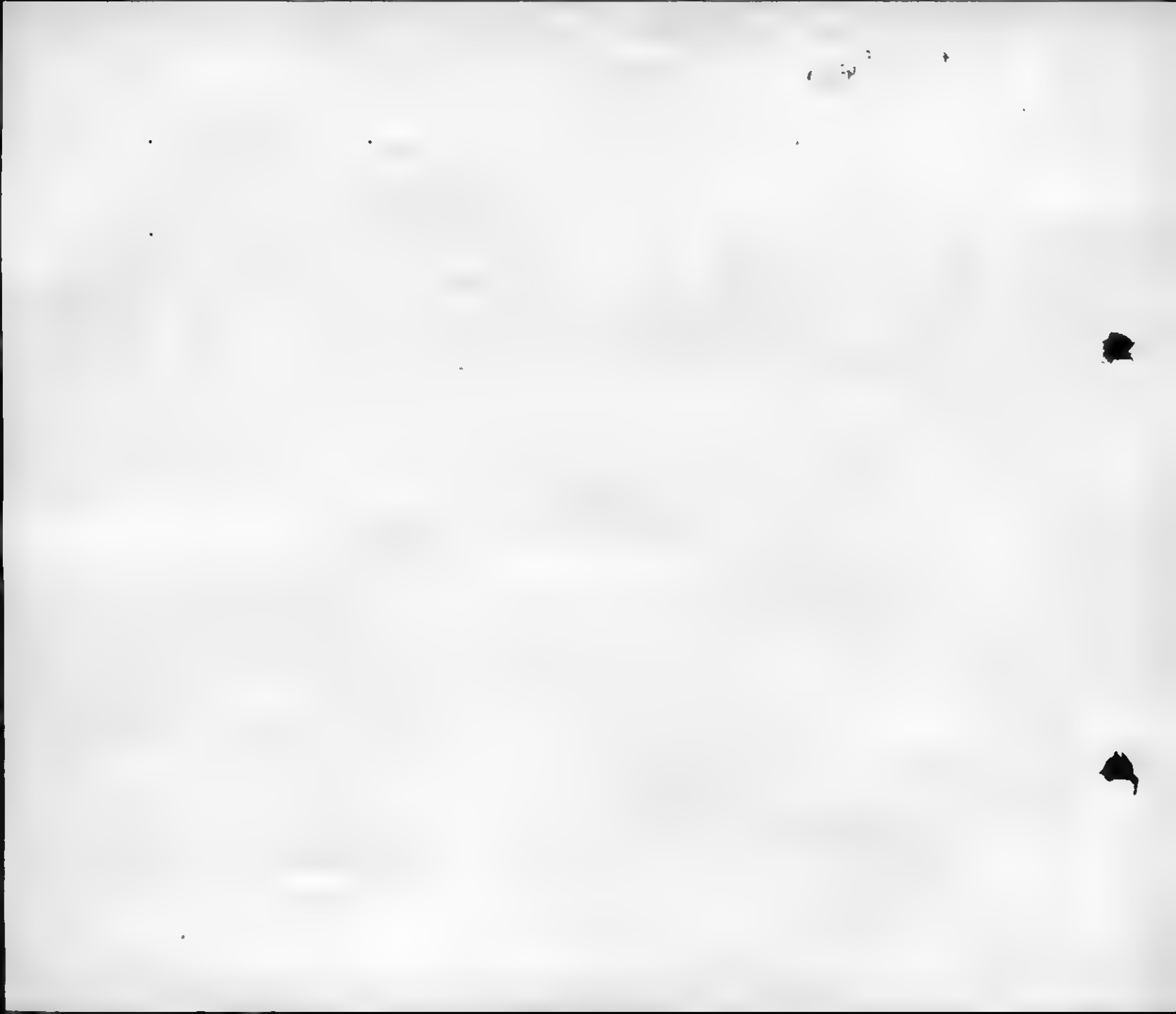
251  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		STATE <u>Md.</u> COUNTY <u>Balto.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>135 S. Symington Ave.</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location) <u>135 S. Symington Ave.</u>			
3. NAME OF DECEASED: (First) <u>EDITH</u> (Middle) <u>L.</u> (Last) <u>ERNSTBERGER</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan.</u> <u>11.</u> <u>1956</u>			
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>July 22, 1887</u>	9. AGE last birthday: <u>68</u> yrs	IF UNDER 1 YEAR: Months <u></u> Days <u></u>	IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>James Ringgold</u>				14. MOTHER'S MAIDEN NAME: <u>Lena Gunther</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <u>no</u>		17. INFORMANT & ADDRESS: <u>Mr. Charles R. Watson - 2641 Purnell Drive</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Coronary vascular Accident</u>						10 min.	
ANTECEDENT CAUSE (B) <u>Hypertension C.V.D.</u>						10 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Cardiac enlargement. Aortic - Mitral Valve disease</u>						20 yrs.	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov.</u> , 19 <u>54</u> to <u>Jan.</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Jan. 11.</u> , 19 <u>56</u> , and that death occurred at <u>10:50 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. Nelson McKay</u>		DATE THEREOF <u>1/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE REC'D BY LOCAL REGISTRAR <u>January 14 1956</u>		REGISTRAR'S SIGNATURE <u>R. W.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Mr. J. Dickner &amp; Sons - Balto. Md.</u>	

MARGIN RESERVED FOR BINP

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore City</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owings Mills.</u>	LENGTH OF STAY (In this place) <u>2 m. 10 d.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood Tr. School</u>		STREET ADDRESS (If rural give location) <u>5702 Park Heights Ave.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>David Christopher Farnell</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>1 27 1956</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>S</u>	8. DATE OF BIRTH: <u>10-7-55</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Robert E. Farnell</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Agnes Christopher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS: <u>Mr. Robert E. Farnell, Jr. - 5702 Park Hgts. Ave.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Bilateral Pneumonitis</u>			<u>48 hrs.</u>
ANTECEDENT CAUSE (B) <u>Congenital Cerebral Defect</u>			<u>since birth</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Congenital Heart Condition</u>			<u>since birth</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Malnutrition</u>			
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OR INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		21E. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Nov. 17, 1956</u> to <u>Jan 27, 1956</u> , that I last saw the deceased alive on <u>Jan. 27, 1956</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Viola B. Johns</u>		ADDRESS <u>Owings Mills Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/30/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>30-56</u>		REGISTRAR'S SIGNATURE <u>Wm. J. Tichner &amp; Louis. Bado</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>17 Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1

259

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

00246

Reg. Dist. No. 30

## 1. PLACE OF DEATH

COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 TOWN Catonsville

MARYLAND  
 LENGTH OF STAY  
 (in this place)  
 26 yrs.

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Paradise Nursing Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN 26 Injoy Ave.  
 STREET ADDRESS (If rural give location)  
 Catonsville

## 3. NAME OF DECEASED (Type or Print)

(First) Julia (Middle) M. (Last) Feilinger

4. DATE OF DEATH (Month) (Day) (Year)  
 Jan. 31 1956

5. SEX

F

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH

1874

9. AGE last birthday

82 yrs.

IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (M'n.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Heide

14. MOTHER'S MAIDEN NAME

Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

Mrs. H. Wilner 26 Injoy Ave.

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A)

DUE TO

Cerebral Thrombosis

ANTECEDENT CAUSE(S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

Arteriosclerosis, generalized cerebral Unknown

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

1 hour

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

White ☐ Not white ☐ at work ☐ M.

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-24, 1955, to 1-31, 1956, that I last saw the deceased alive on 1-30, 1956, and that death occurred at 2:00 P.M. from the causes and on the date stated above.

SIGNATURE

Stephen L. Napier M.D.

ADDRESS (Street, city, town, state)

Charmville 28 Md 2-2-56

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE Feb. 6, 1956

Victor E. Hays

Frederick J. Hays Funeral Home, Baltimore, Md.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



260

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>id</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fullerton</u>		<u>48 yrs</u>		TOWN <u>Fullerton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bucks School House Rd</u>				STREET ADDRESS (If rural give location) <u>Bucks School House Rd</u>			
3. NAME OF DECEASED (Type or Print) <u>C H O P Fiedler</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 22 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 30-1882</u>	9. AGE last birthday <u>73 yrs.</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Himself</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernst W Fiedler</u>				14. MOTHER'S MAIDEN NAME <u>Emma E Grahl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Minnie Fiedler, Bucks School House Rd</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
42a. IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis 1 yr</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 4 1955</u> to <u>Jan 22 1956</u> , that I last saw the deceased alive on <u>Jan 21 1956</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Diogen</u>		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED <u>1-23-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>St Peters Luth. Cem</u>		LOCATION (City, town, or county) (State) <u>Balto id</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. A. L. Reifreder</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lorraine Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
DATE <u>Jan 24 1956</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No.

Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Balt.</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Balt. City</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Mt. Wilson</i>		LENGTH OF STAY (in this place) <i>17 hrs</i>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Balt.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Mt Wilson Hosp.</i>				STREET ADDRESS <i>1216 Brentwood Ave.</i> <i>Balt.</i>			
3. NAME OF DECEASED: (Type or Print) <i>HENRY EDWARD FINCH</i>				4. DATE OF DEATH <i>Jan 29 1956</i>			
5. SEX: <i>M.</i>		6. COLOR OR RACE: <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>		8. DATE OF BIRTH: <i>7-17-24</i>	
9. AGE last birthday: <i>31</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>City Sanitation Sanitation</i>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Balt., Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME: <i>Harry Finch</i>				14. MOTHER'S MAIDEN NAME: <i>Catherine Hughes</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY No.: <i>220-14-5298</i>		17. INFORMANT & ADDRESS: <i>Mt. Wilson Hosp Records</i>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)..... <i>Pleural Effusion</i>	
Antecedent cause(s)	(b)..... <i>Pulmonary Tbc.</i>	<i>3 1/2 yrs</i>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <i>none</i>		19b. MAJOR FINDING OF OPERATION: <i>none</i>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <i>none</i>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <i>none</i>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>none</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>none</i>	
21f. HOW DID INJURY OCCUR? <i>none</i>			

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE *Dr. Caples*

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED *1-29-56*  
 DEPUTY MEDICAL EXAMINER ☐  
 M. D. ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF: <i>2/1/56</i>	NAME OF CEMETERY OR CREMATORY: <i>Holy Redeemer Cemetery</i>	LOCATION (City, town, or county) (State): <i>Baltimore, Maryland</i>
DATE REC'D BY LOCAL REG. <i>30-56</i>	REGISTRAR'S SIGNATURE: <i>[Signature]</i>	24. FUNERAL DIRECTOR: <i>William Cook Inc 27 S. Bond Street Baltimore</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



262

## CERTIFICATE OF DEATH

Reg. Dist. No. 00249

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Spanners Pt. LENGTH OF STAY (in this place)  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Balto.  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Spanners Pt.  
 STREET ADDRESS (If rural, give location) Box 104 Pt. Pt. Rd.

## 3. NAME OF DECEASED:

(First) THOMAS (Middle) J. (Last) Forbes  
 (Type or Print)

4. DATE OF DEATH: 1 - 5 19 56  
 (Month) (Day) (Year)

## 5. SEX:

M

## 6. COLOR OR RACE:

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Single

## 8. DATE OF BIRTH:

Mar 10 - 1861

## 9. AGE last birthday:

94 yrs.

## 10. IF UNDER 1 YEAR

Months Days Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FARMER

## 10b. KIND OF BUSINESS OR INDUSTRY:

RETIRED

## 11. BIRTHPLACE (State or foreign country):

Va

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Angus Forbes

## 14. MOTHER'S MAIDEN NAME:

Unknown

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Bertie Swisher (Same)

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

## Immediate cause

(a) DUE TO

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

## PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1953, to Jan 5, 1956, that I last saw the deceased alive on Jan 5, 1956, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

## SIGNATURE

[Signature]

## (DEGREE OR TITLE)

M.D.

## ADDRESS

520 2nd

Balto 19 2nd

## DATE SIGNED

1/6/56

## 23. BURIAL, CREMATION REMOVAL (Specify):

Burial

## DATE THEREOF

1-7-56

## NAME OF CEMETERY OR CREMATORY

Oak Lawn

## LOCATION (City, town, or county)

Balto

## (State)

Md.

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

[Signature]

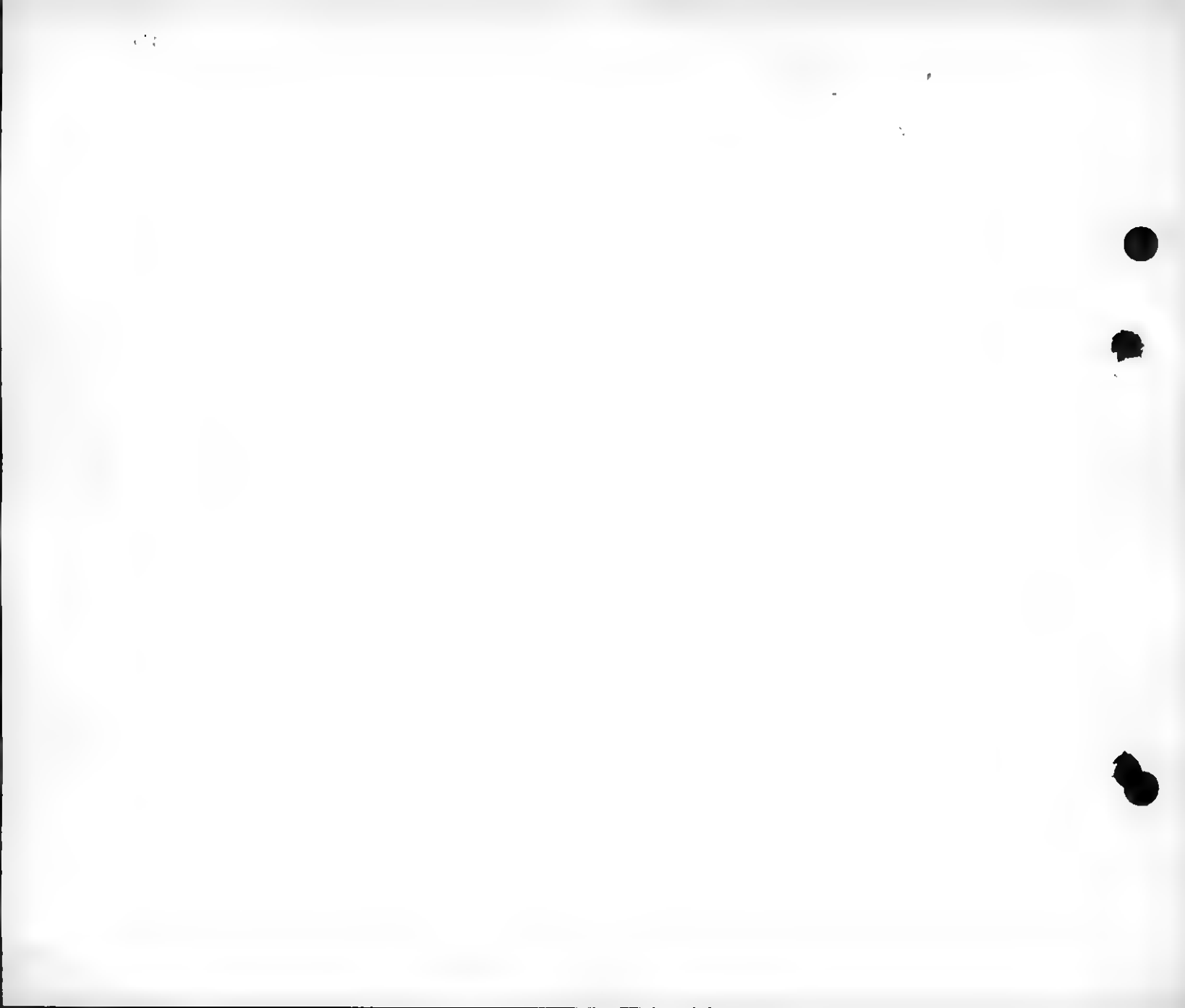
## 24. FUNERAL DIRECTOR

[Signature]

## ADDRESS

Essex Md

MARGIN RESERVED FOR BINDING





263

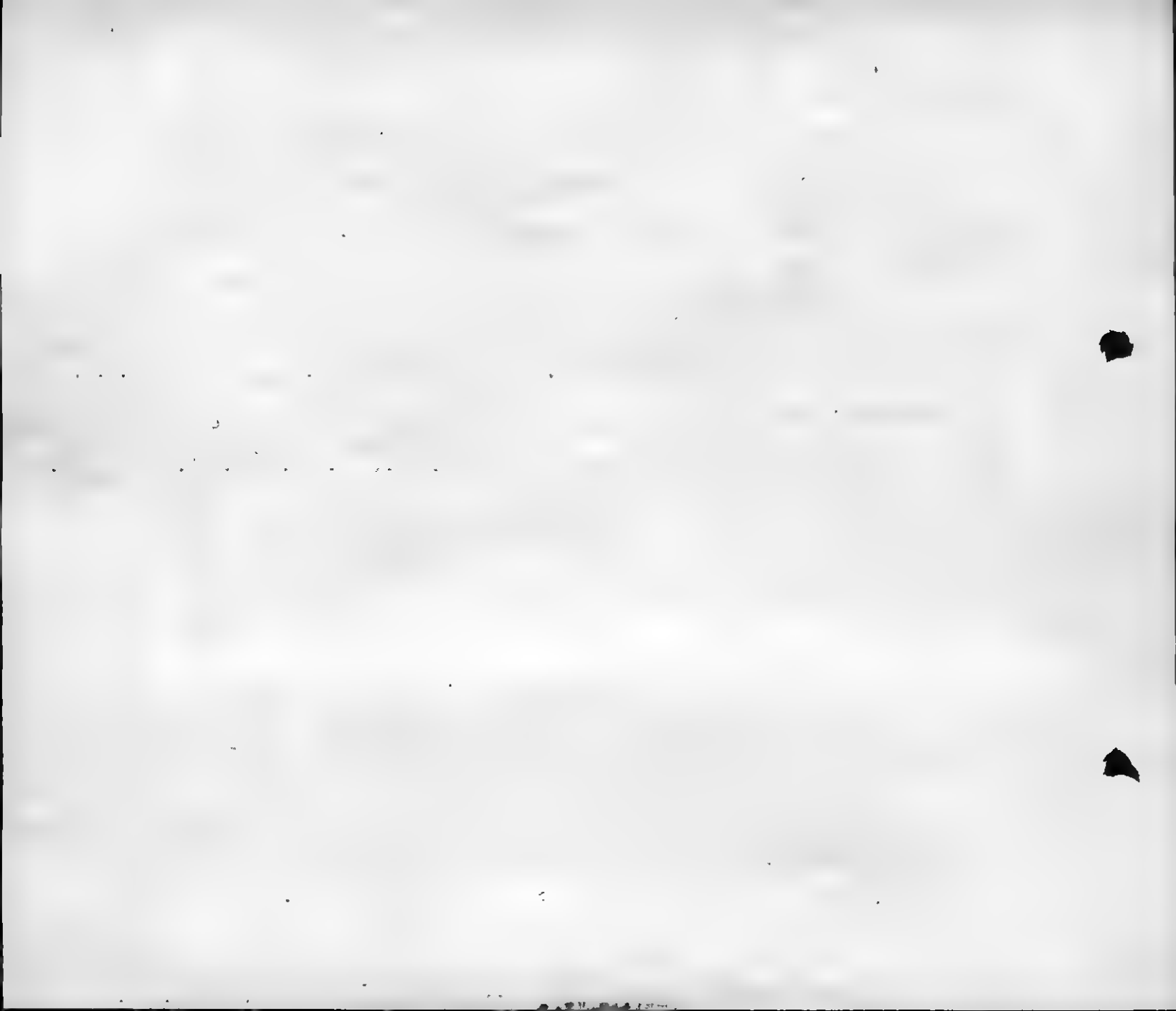
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u>		LENGTH OF STAY in this place <u>17 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>130 N. Carlton Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WILLIAM</u> <u>FORD</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>January 1</u> <u>1956</u>			
5. SEX. <u>Male</u>		6. COLOR OR RACE. <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>10/2/02</u>	
9. AGE last birthday <u>53</u> yrs		10. MONTHS <u>1</u> Days <u>1</u> Hours <u>1</u> Min.		11. BIRTHPLACE (State or foreign country): <u>Prospect, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Truck Helper</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Transfer Co.</u>			
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Betty (Middle name unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>BRONCHOGENIC CARCINOMA LEFT UPPER LOBE</u>						UNKNOWN	
ANTECEDENT CAUSE (B) <u>WITH METASTASES TO ADRENALS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that <u>VA</u> attended the deceased from <u>Dec 15</u> , 19 <u>55</u> , to <u>Jan 1</u> , 19 <u>56</u> , and that death occurred at <u>5:30A</u> M., from the causes and on the date stated above.							
SIGNATURE <u>DONALD D. MARK</u>		M. D. <u>Fort Howard, Md.</u>		DATE SIGNED <u>1/2/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>Sulphur Spring Baptist Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>Prospect, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
SHIPPED TO: <u>Bland Funeral Home, 412 Ely St., Baltimore, Md.</u>				<u>Charles R. Law Funeral Home</u>		<u>802-04 Madison Ave., Balto., Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



264

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Fort Howard</u>		<u>37 Days</u>		OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>2524 Ruscombe Lane</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>PHILIP FORSHLAGER</u>				<u>January 4 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>November 1, 1894</u>	9. AGE last birthday: <u>61</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Collector</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Installment</u>		11 BIRTHPLACE (State or foreign country): <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Abraham Forshlager</u>				14. MOTHER'S MAIDEN NAME: <u>Blooma MN: Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>218-30-5856</u>			
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A) <u>BRONCHOGENIC CARCINOMA, LEFT LUNG</u>				UNKNOWN	
ANTECEDENT CAUSE (B)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO					
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>METASTATIC CARCINOMA OF THORACIC SPINE</u>							
19A. DATE OF OPERATION: <u>12-13-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Excision of left axillary node for biopsy</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 28, 1955, to Jan. 4, 1956</u> , and that death occurred at <u>2:50AM</u> , from the causes and on the date stated above.							
SIGNATURE: <u>Francis G. Dickey</u>		ADDRESS: <u>M.P. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED: <u>1-4-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF: <u>1-5-56</u>		NAME OF CEMETERY OR CREMATORY: <u>Rosedale Cemetery</u>		LOCATION (City, town, or county) (State): <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>1/5/56</u>		REGISTRAR'S SIGNATURE: <u>[Signature]</u>		24. FUNERAL DIRECTOR: <u>Jack Lewis, Inc.</u>		ADDRESS: <u>2100 Eutaw Pl. Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 265 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CATON Ridge HOME MARYLAND</u>				STATE <u>MARYLAND</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>(28) BALTIMORE</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CATON Ridge Nursing Home.</u>				STREET ADDRESS (If rural give location) <u>1909 Victory Drive (27)</u>			
3. NAME OF DECEASED (Type or Print) <u>ALFRED</u> (First) <u>M.</u> (Middle) <u>FOWLER JR.</u> (Last)				4. DATE OF DEATH <u>JAN. 4, 1956</u> (Month) (Day) (Year)			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>APRIL 6, 1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Koppers Co.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALFRED M. FOWLER SR.</u>				14. MOTHER'S MAIDEN NAME <u>LILLIE M. LEWIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>216-05-5213</u>		17. INFORMANT & ADDRESS <u>Mrs. Mabel L. Fowler (27)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebrovascular Hemorrhage -</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension - severe</u>						<u>Death due</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 4</u> , 19 <u>56</u> , to <u>Jan 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>56</u> , and that death occurred at <u>4:30</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Carl E. Edwards</u>				ADDRESS (Street, city, town, state) <u>4605 Edmondson Ave</u>		DATE SIGNED <u>Jan 6, 1956</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>ELEN HAVEN CEM.</u>		LOCATION (City, town, or county) <u>ELEN BURNIE Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 9, 1956</u>		REGISTRAR'S SIGNATURE <u>T. E. Garvey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. Truman Schuch</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



265

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) (in this place)  
 TOWN Riderwood  
 HOSPITAL OR Soreman Nursing Home  
 INSTITUTION OR STREET ADDRESS 7912 Ruxway Road.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Baltimore  
 STREET ADDRESS (If rural give location)  
unknown.

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE OF DEATH

(Month)

(Day)

(Year)

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

DUE TO

Antecedent causes(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO

(c)

Interval Between Onset And Death

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT (Specify)  
SUICIDE  
HOMICIDE NonePLACE (Home, farm, factory, street, office bldg., etc.)  
OF INJURY none

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY no injury m.INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 10, 1955, to Jan. 14, 1956, that I last saw the deceasedSignature James Graham Harrison MD ADDRESS 516 Cathedral St. DATE SIGNED Jan 14, 1956

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

JAN 30 1956

Huntington Williams, M.D.

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V. 5-70

DUPLICATE A. 2

FEB





**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OF HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

267

**CERTIFICATE OF DEATH**

00254

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		OR TOWN <u>Baltimore</u>		TOWN <u>Baltimore</u>	
TOWN <u>Fort Howard</u>		<u>3 Days</u>		STREET ADDRESS (If rural give location)		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				<u>4837 Hazelwood Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>HENRY</u> (First) <u>FRANKENBERGER</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>January 5</u> <u>1956</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>March 22, 1888</u>		<b>9. AGE last birthday</b> <u>67</u> yrs.	<b>IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Raspeborge, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Henry Frankenger</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Wilehmina Klingler</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW I</u>		<b>16. SOCIAL SECURITY NO.</b> <u>218-32-0405</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>IMMEDIATE CAUSE (A)</b> <u>GLIOMA SUBTHALMIC</u>						<u>1 YEAR</u>	
<b>ANTECEDENT CAUSE(S) (B)</b> <u>None</u> (Further clarification if necessary available in one week)							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>ACUTE CEREBRAL EDEMA</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that</b> <u>VA</u> <u>attended the deceased from Jan. 2, 1956, to Jan. 5, 1956, and that death occurred at 2:00 A.M. from the causes and on the date stated above.</u>							
<b>SIGNATURE</b> <u>Donald D. Mark, M.D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u>			
<b>DATE SIGNED</b> <u>1/5/56</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>1/9/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Parkwood Cemetery</u>		<b>LOCATION (City, town, or county)</b> <u>Baltimore, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>1/5/56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>James L. Farber</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lassahn Funeral Home</u>		<b>ADDRESS</b> <u>7401 Belair Rd. Balto. Md.</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No. 32

Item 2, Film 6111-1-10-56 et

1. PLACE OF DEATH: <i>Rosewood State Training School</i>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Owings Mills -</i>	LENGTH OF STAY (In this place) <i>7.25.53</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>FALL HAVEN Md. Bal Air</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Rosewood State Training School -</i>		STREET ADDRESS <i>118 S. Main Street</i>	
3. NAME OF DECEASED: (First) <i>Marguerite</i> (Middle) <i>-</i> (Last) <i>Fuhrman</i>		4. DATE OF DEATH: (Month) <i>1</i> (Day) <i>1</i> (Year) <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <i>2.8.1914</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <i>41</i> yrs
11. BIRTHPLACE (State or foreign country): <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME: <i>Harry F. Fuhrman</i>		14. MOTHER'S MAIDEN NAME: <i>Elizabeth M. Fuhrman</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>---</i>	
17. INFORMANT & ADDRESS: <i>Harford Co. Commission Mr. T. Leo Sullivan</i>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE		<i>Acute Bronchitis with</i>	
(B) ANTECEDENT CAUSE (S)		<i>Bronch. Pneumonia and</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		<i>Diabetes mellitus - (undemonstrated)</i>	
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<i>Congenital cerebral malformation of brain with symptomatic Epilepsy</i>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>31 Dec</i> , 1955, to <i>1 Jan</i> , 1956, that I last saw the deceased alive on <i>1 Jan</i> , 1956, and that death occurred at <i>3:30 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Harry B. Butler</i>		DATE SIGNED <i>1/2/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Jan 3/56</i>	
NAME OF CEMETERY OR CREMATORY <i>St. Ignace</i>		LOCATION (City, town, or county) (State) <i>Hickory Hartford Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>1956</i>		24. FUNERAL DIRECTOR <i>Truitt Funeral Home, Inc. W. Truitt</i>	
REGISTRAR'S SIGNATURE <i>Mary Elmer</i>		ADDRESS <i>Baltimore, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 5 1900

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH**

**2411 N. Charles Street, Baltimore**

269

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

**MARGIN RESERVED FOR BLENDING**

VS. A15

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		Maryland		COUNTY		Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town)		Hebbsville		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		Hebbsville		TOWN		Hebbsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		7212 Windsor Mill Road		STREET ADDRESS		7212 Windsor Mill Road		(If rural, give location)					
3. NAME OF DECEASED (Type or Print)		(First) Charles		(Middle) P.		(Last) Garriott		4. DATE OF DEATH		(Month) Jan.		(Day) 4th	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE last birthday		If under 1 year		If under 24 hrs	
Male		White		Widowed		Jan. 19, 1870		85 yrs.		Months		Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Retired Florist		Florist		Wrie, Pennsylvania		Country							
13. FATHER'S NAME		Charles A. Garriott		14. MOTHER'S MAIDEN NAME		Frances Oyce							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS		Mrs. M. Roherer, 7212 Windsor Mill Road							
No		None											
18. MEDICAL CERTIFICATION													
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH												INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) -- <i>Spontaneous Ca. Prostate</i>												— ?	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last													
(b) — <i>Stenosis of aorta</i>													
(c) —													
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.													
19a. DATE OF OPERATION													
19b. MAJOR FINDINGS OF OPERATION													
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>													
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?									
OF INJURY		While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>											
22. I hereby certify that I attended the deceased from <i>Dec 12, 1955</i> , to <i>Jan 3, 1956</i> , that I last saw the deceased alive on <i>Jan 3, 1956</i> , and that death occurred at <i>4:30 A.M.</i> , from the causes and on the date stated above.													
SIGNATURE: <i>Dr. Thos. G. Roberts</i>				(Degree or title)				ADDRESS: <i>4509 Liberty Heights ve. Jan. 4th/56</i>				DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)					
Burial		Jan. 6, 1956		Mt. Clive Cemetery		Baltimore, Md.		Baltimore					
DATE REC'D BY LOCAL REG.		1/4/56		REGISTRAR'S SIGNATURE		A. H. Henderson		24. FUNERAL DIRECTOR		4510 Liberty Heights ve.			



PLEASE WRITE PLAIN INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

210 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00257

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <i>Elmer V. Garrity</i>			2. DATE OF DEATH <i>Jan. 14, 1956</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>2100. Smith Ave</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>2100 Smith Ave Baltimore, Md</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
c. Length of stay in Baltimore <i>Life</i>			D. STREET ADDRESS (If rural, give location) <i>2100 - Smith Ave</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Jan. 12, 1912</i>	9. AGE (In years last birthday) <i>43</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shaver</i>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>William Garrity</i>			14. MOTHER'S MAIDEN NAME <i>Mary Brooks</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>213-05-7745</i>		
17. INFORMANT <i>Julia Garrity, 2100 - Smith Ave, Baltimore</i>			ADDRESS		
18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Coronary Occlusion</i>			INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Coronary Heart Disease</i>			(B) <i>2</i> <i>possibly about 1 or 2 years</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C)		
19A. DATE OF OPERATION			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21A. TIME (Month) (Day) (Year) (Hour) OF INJURY			21B. MAJOR FINDINGS OF OPERATION		
21C. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21D. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>Jan 14, 1956</i> to <i>Jan 14, 1956</i> , that I last saw the deceased alive on <i>Jan 14, 1956</i> , and that death occurred at <i>2:45 pm</i> from the causes and on the date stated above.					
23A. SIGNATURE <i>Leonard Walkenstein M.D.</i>			23B. ADDRESS <i>848 W 36th St</i>		
23C. DATE SIGNED <i>1/16/56</i>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>Jan. 18, 1956</i>		
24C. NAME OF CEMETERY OR CREMATORY <i>Duval Ridge</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>		
DATE RECEIVED BY LOCAL REGISTRAR <i>1/16/56</i>			25. FUNERAL DIRECTOR <i>Carl B. Wolston Funeral Home, Inc.</i>		





271

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

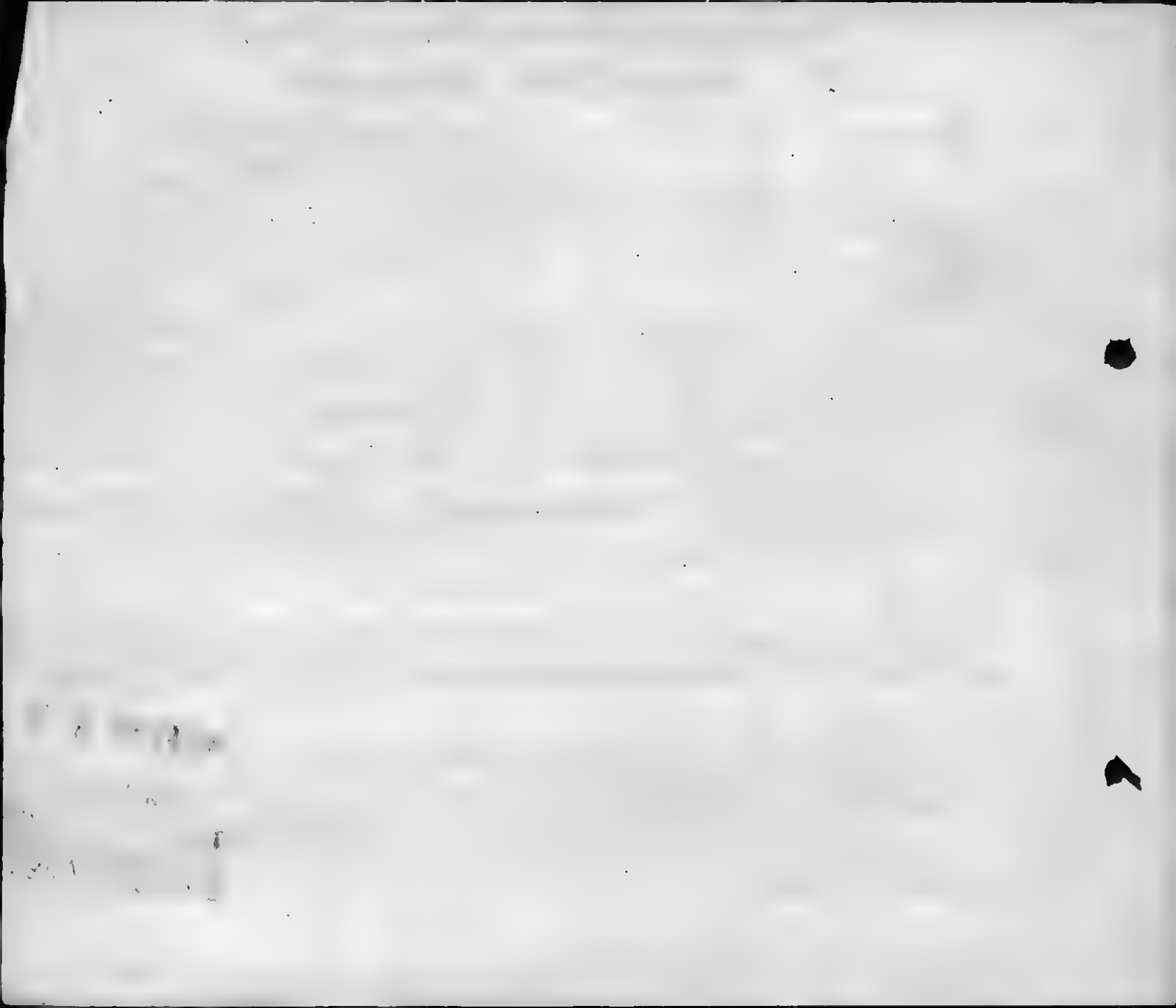
INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		STATE <u>Md</u> COUNTY <u>Balto</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		LENGTH OF STAY (in this place) <u>6 months</u>		STREET ADDRESS <u>3904 W. Cold Spring Lane</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Caton Ridge Nursing Home</u>		3. NAME OF DECEASED (Type or Print) <u>George C. T. Gilbert</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>20</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 13, 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Kenna</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Gilbert</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>218-32-7546</u>		17. INFORMANT'S ADDRESS <u>Mac Elmer M. Hargrave 2714 K. St. Baltimore</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiac failure</u>				<u>2 1/2 hrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio sclerosis</u>				<u>Unknown</u>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, or injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Balto</u> , 19 <u>55</u> , to <u>Jan 20, 1956</u> , that I last saw the deceased alive on <u>Jan 19, 1956</u> , and that death occurred at <u>9:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Chas. Robert J.</u>		M.D. <u>4605 Edmondson Ave</u>		DATE SIGNED <u>1/21/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Funeral</u>		DATE THEREOF <u>1/23/56</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>		LOCATION (City, town, or county) <u>Balto</u>	
24. REGD BY REGISTRAR <u>Jan. 24, 1956</u>		REGISTRAR'S SIGNATURE <u>V. E. Harvey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byars</u>		ADDRESS <u>5005 Rk. Hlth Rd. Balto 15, Md.</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH

272

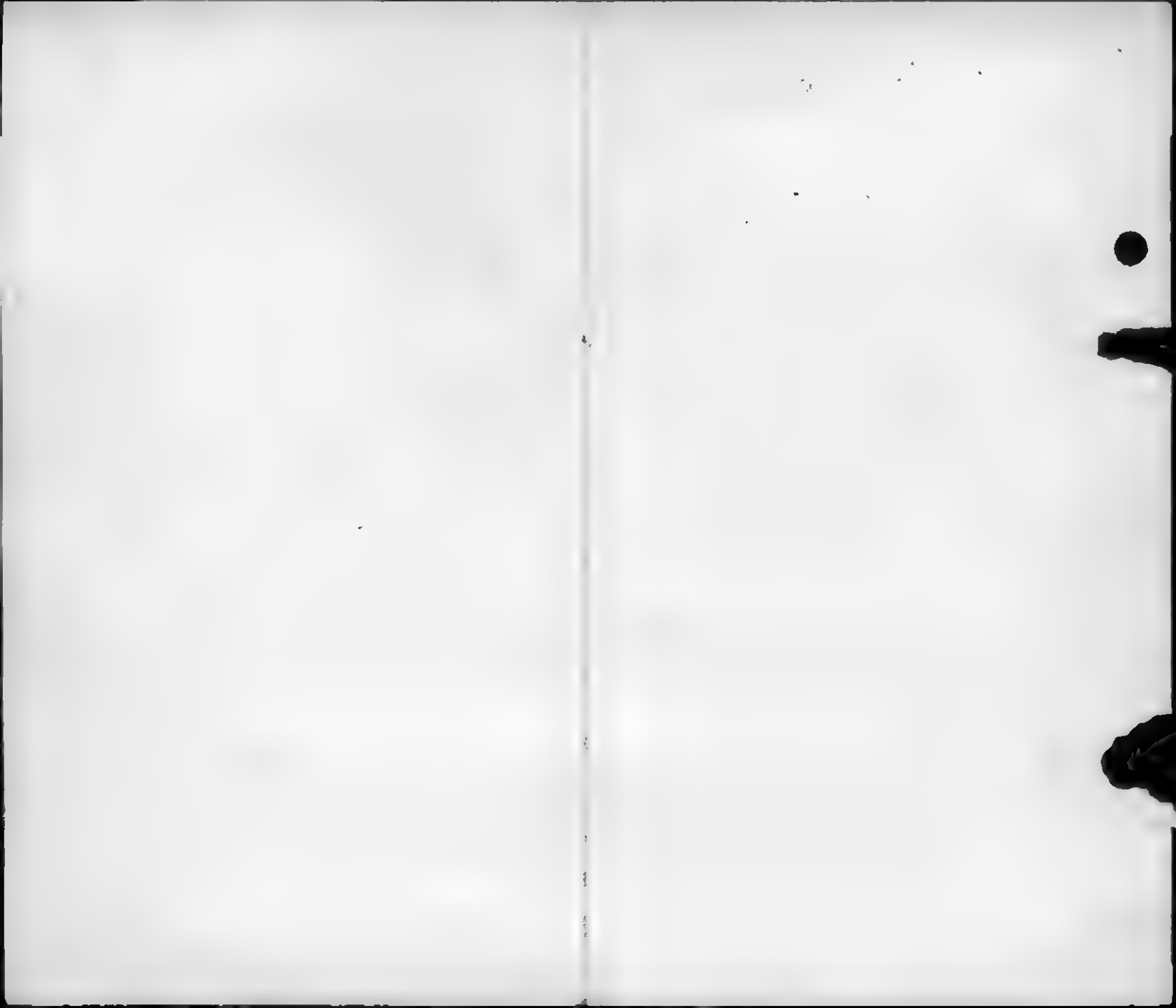
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SAVON POINT</u> -		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beth Steel Inspenig.</u>		STREET ADDRESS (If rural, give location) <u>420 S. NEWKIRK ST.</u>	
3. NAME OF DECEASED (Type or Print) <u>Paul</u> (First) <u>Michael</u> (Middle) <u>Goecke</u> (Last)		4. DATE OF DEATH <u>1-20</u> (Month) <u>1956</u> (Year)	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAR. 11, 1913</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHECKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BETH STEEL CO.</u>	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>
13. FATHER'S NAME <u>OTTO GOECKE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W.II</u>		14. MOTHER'S MAIDEN NAME <u>JUSTINE ROHLEDER.</u>	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>LILLIAN GOECKE</u> <u>SAME.</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Compound Fracture of Skull - Fractured</u>			
Antecedent cause(s) (b) <u>Regimen, just above natural eye</u>			
(c) <u>None</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, or office) <u>420 S. NEWKIRK ST.</u> (CITY OR TOWN) <u>BALTIMORE</u> (COUNTY) <u>MD.</u> (STATE) <u>MD.</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1-20-56-4:48</u> m.		INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? <u>Found was caught between crane &amp; furnace</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Michael M. S.</u> (Degree or title) <u>Dep. Med. Exam.</u>		DATE SIGNED <u>1/20/56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>1-24-56</u>	
NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL CEM.</u>		LOCATION (City, town, or county) <u>5501 FREDERICK AVE. BALTO. MD.</u>	
DATE REC'D BY LOCAL REG. <u>1/23/56</u>		24. FUNERAL DIRECTOR <u>Charles S. Seiler</u> ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



273

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

00260

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Catonsville</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Pikesville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Spring Grove State Hospital</b>		STREET ADDRESS (If rural, give location) <b>4 Salem Court</b>	
3. NAME OF DECEASED (Type or Print) <b>Jeanette</b>		4. DATE OF DEATH <b>January 17, 1956</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>		8. DATE OF BIRTH <b>1905</b>	
9. AGE last birthday <b>60</b> yrs.		10. If under 1 year: Months <b>1</b> Days <b>17</b> Hours <b>19</b> Min. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No. <b>Unknown</b>	
17. INFORMANT AND ADDRESS <b>Records Spring Grove State Hospital</b>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>Pulmonary abscesses</b>		<b>Unk.</b>
Antecedent cause(s) (b) <b>Diabetes Mellitus</b>		<b>Unk.</b>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Fracture of right hip</b>		Approx. <b>5wks.</b>
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY! Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	(CITY OR TOWN) <b>Pikesville</b> (COUNTY) <b>Baltimore Md.</b> (STATE)
TIME (Month) (Day) (Year) (Hour) <b>Approx. 12-20-55 4:15 a.m.</b>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <b>Unknown. Family states she fell while at home.</b>

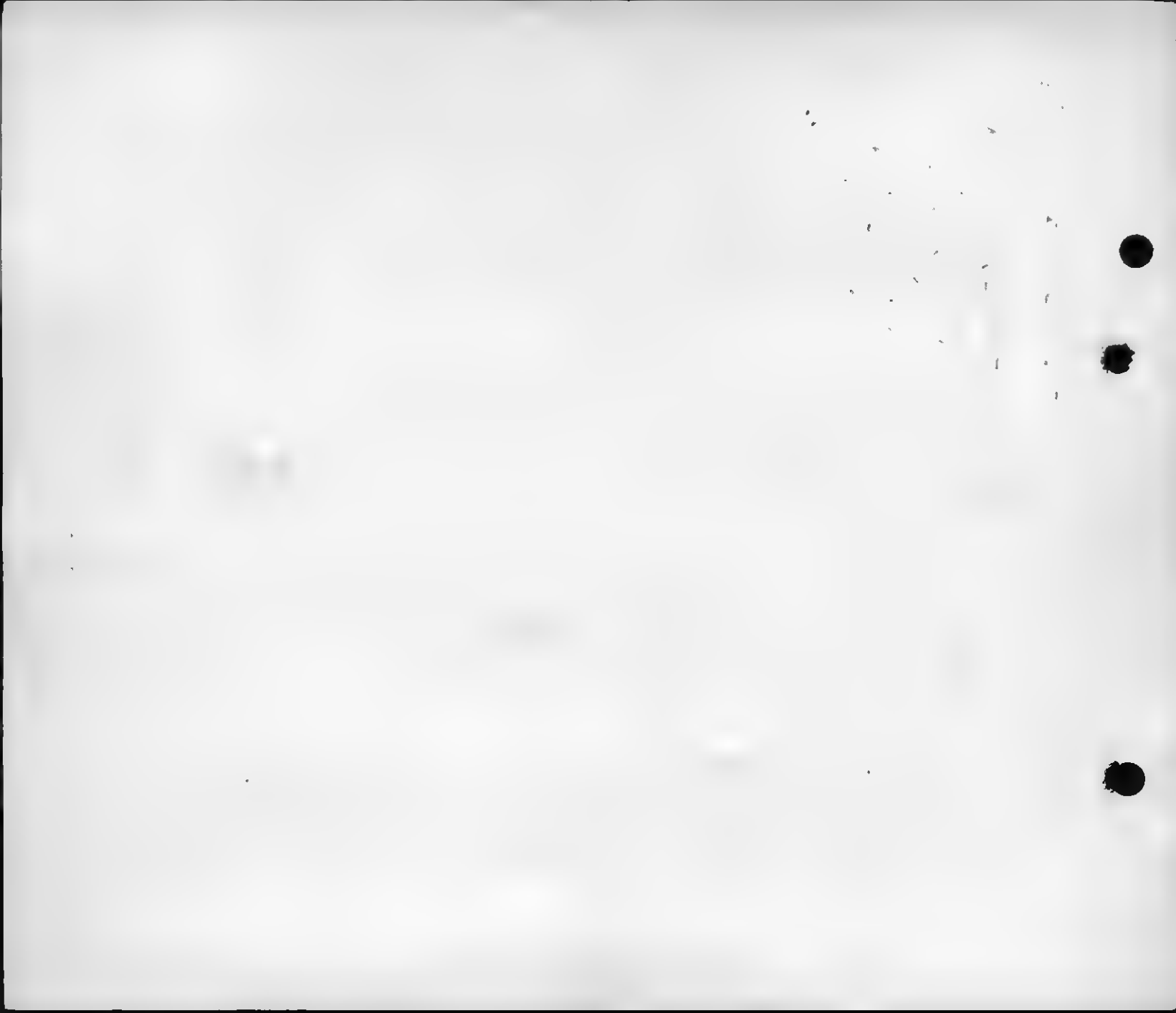
22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE **Dr. M. Kieffer** (Degree or title) ADDRESS **1010 Leeds Avenue** DATE SIGNED **1-17-56**  
**Arbutus, Maryland**

23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>Jan 18 1956</b>	NAME OF CEMETERY OR CREMATORY <b>Charles E. Smith</b>	LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE REC'D BY LOCAL REG. <b>1-18-56</b>	REGISTRAR'S SIGNATURE <b>John H. ...</b>	24. FUNERAL DIRECTOR <b>1124-26 N. ...</b>	ADDRESS <b>Sold ...</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

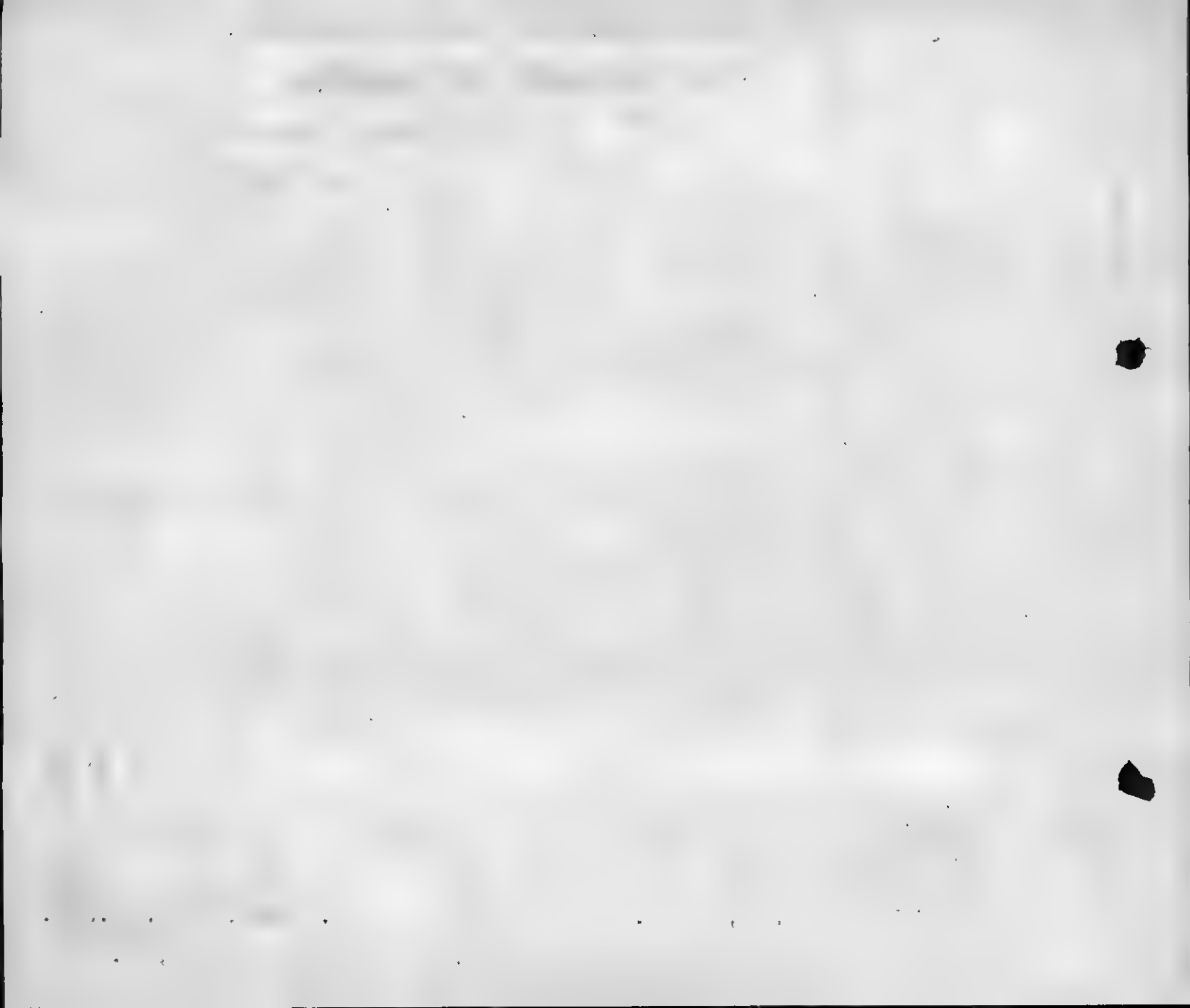
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271

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)	
TOWN <u>Mount Carmel</u>				TOWN <u>Mount Carmel</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mount Carmel</u>				STREET ADDRESS (If rural give location) <u>Mt. Carmel</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LEWIS</u> (Middle) <u>ALBERT</u> (Last) <u>GORSUCH</u>				(Month) <u>JANUARY</u> (Day) <u>8</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>July 30, 1860</u>	9. AGE last birthday <u>95</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Gorsuch</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Shamburger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT & ADDRESS <u>Miss Grace Miller, Spunk Md</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerotic Cardio-Vascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) _____		21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>July 8, 1956</u> to <u>Jan 8, 1956</u> , that I last saw the deceased alive on <u>Jan 8, 1956</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Joseph E. Bush</u> M.D. <u>Hammond Md</u>				ADDRESS (Street, city, town, state) <u>Jan 8, 1956</u>			
23. BURIAL INFORMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 11, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mt. Carmel, Balto., Co., Md.</u>	
24. REG'D BY REGISTRAR <u>1-12-56</u>		REGISTRAR'S SIGNATURE <u>Mrs. Howard S. Mainline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons</u>		ADDRESS <u>Towson, Md.</u>	





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

275

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonsville</u>	LENGTH OF STAY (In this place) <u>1 week</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Reisterstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Fusting Avenue</u>		STREET ADDRESS (If rural give location) <u>Nicodemus Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Joseph Milton Gosnell</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>13</u> <u>1956</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>April - 1872</u>
9. AGE last birthday <u>83</u> yrs.		10. IF UNDER 1 YEAR, Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Self employed</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>George W Gosnell</u>		14. MOTHER'S MAIDEN NAME: <u>Keziah E Gosnell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Daniel Phillips Reisterstown Md</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Acute Cardiac Dilatation</u>			<u>10 mos.</u>
ANTECEDENT CAUSE (B) <u>Hypertensive Cardio-Vasc. Renal Disease</u>			<u>10 yrs?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Left Hydronephrosis &amp; Hydroneuritis</u>			
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-6</u> , <u>1956</u> , to <u>1-13</u> , <u>1956</u> , that I last saw the deceased alive on <u>1-13</u> , <u>1956</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>M. K. Gallagher</u>		ADDRESS <u>M. D. 6209 Frederick Ave. Balt 28</u>	DATE SIGNED <u>1-13-56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Jan 16 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Reisterstown Meth Cem</u>	LOCATION (City, town, or county) (State) <u>Reisterstown Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>1-15-56</u>	REGISTRAR'S SIGNATURE <u>Mary B. ?</u>	24. FUNERAL DIRECTOR <u>Wm Berryman &amp; Sons</u>	ADDRESS <u>Reisterstown Md</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 19 1956

BUREAU V. S.

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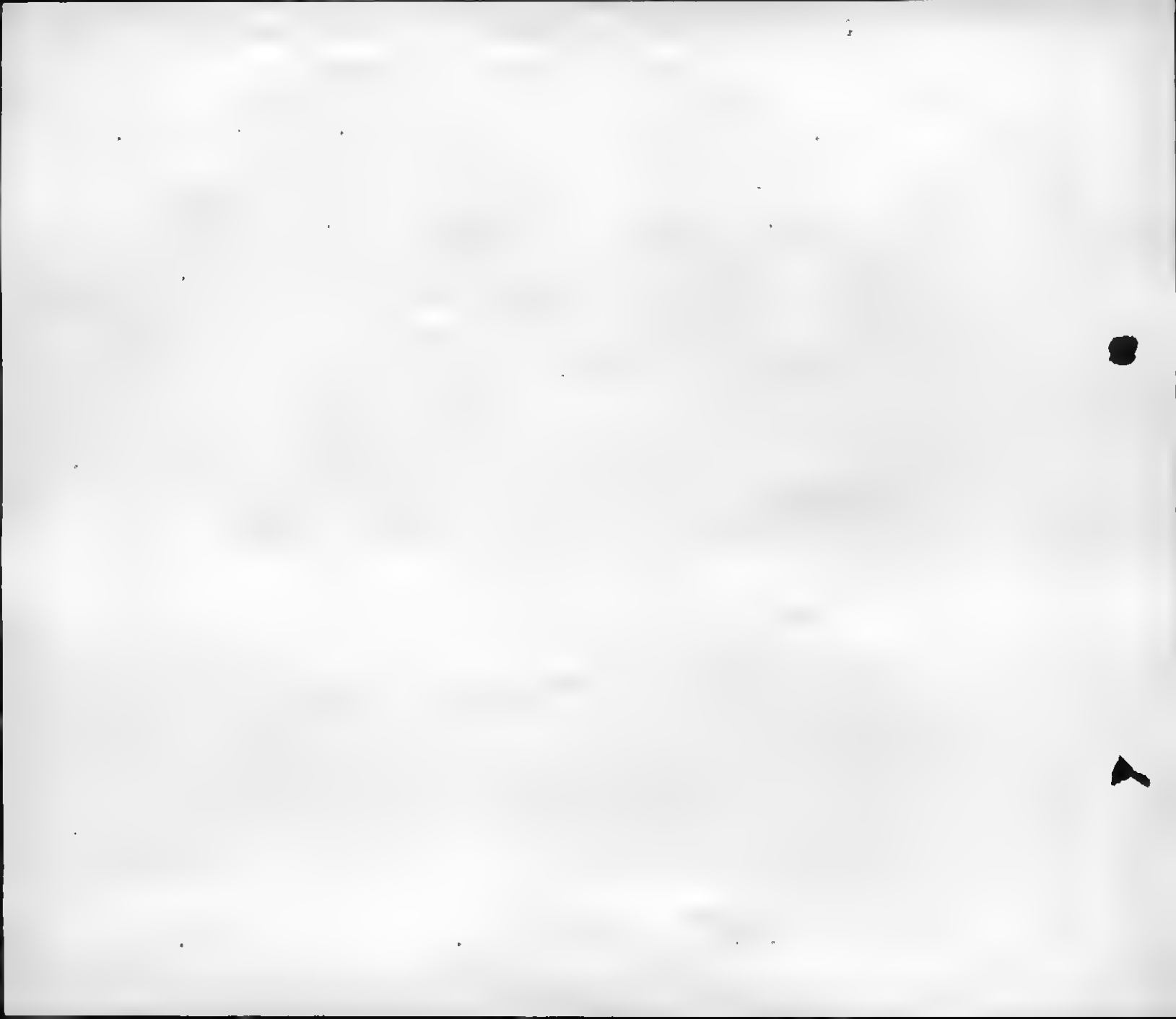
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Balto.</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Balto.</b>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<input checked="" type="checkbox"/> TOWN <b>Gray Manor</b>		OR TOWN <b>Gray Manor</b>	<input checked="" type="checkbox"/>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>7 N. Point Terrace</b>		STREET ADDRESS (If rural give location) <b>7 N. Point Terrace</b>	<input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or Print) <b>Maxam L Goudy</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>Jan. 14, 1956</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>September 11, 1911</b>
9. AGE last birthday: <b>44</b> yrs		10. BIRTHPLACE (State or foreign country): <b>Baltimore Md.</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Solicitor</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Notley Goudy</b>		14. MOTHER'S MAIDEN NAME: <b>Jessie Browne</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <b>Mrs. Elda Goudy - 7 N. Point Terr.</b>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b>			
ANTECEDENT CAUSE (B) <b>Malignant Hypertension</b>		<b>3 months</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Leukemia</b>		<b>3 months</b>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Nov. 16, 1955</b> to <b>Jan. 14, 1956</b> that I last saw the deceased alive on <b>Jan. 11, 1956</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>John C. McLean M.D.</b>		ADDRESS <b>M. D. Gray Manor Med. Center</b>	
DATE SIGNED <b>1/14/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1.18.56</b>	
NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>1-6-56</b>		REGISTRAR'S SIGNATURE <b>John C. McLean</b>	
		FUNERAL DIRECTOR <b>Wm. J. Sweeney &amp; Sons - Balto. 17 Md.</b>	

MARGIN RESERVE FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Md.</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Handers-town</u>		TOWN <u>Gett</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)			
		<u>Highway R.D. #3</u>			
3. NAME OF DECEASED:		4. DATE OF DEATH		5. AGE last birthday:	
(First) (Middle) (Last)		(Month) (Day) (Year)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>Curry Lee Graybeal</u>		<u>1-7-56</u>		Months Days Hours Min.	
6. SEX: <u>M</u>		7. COLOR OR RACE: <u>W</u>		8. DATE OF BIRTH: <u>Nov. 3, 1955</u>	
9. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>	
12. FATHER'S NAME: <u>Carl Graybeal</u>		13. MOTHER'S MAIDEN NAME: <u>Kate Horber</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>McHargal - Highville, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) Immediate cause DUE TO <u>Older media</u>		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO		
(c) stating underlying cause last		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
19a. DATE OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
19b. MAJOR FINDING OF OPERATION:		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE William V. Smith CHIEF MEDICAL EXAMINER DATE SIGNED 1-7-56  
 M. D. ASSISTANT MEDICAL EXAM. 1-7-56

23. BURIAL, CREMATION, REMOVAL, (Specify): <u>burial</u>	DATE THEREOF: <u>1-9-56</u>	NAME OF CEMETERY OR CREMATORY: <u>Bethesda</u>	LOCATION (City, town, or county) (State): <u>Gett, Carroll, Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan. 8, 1956</u>	REGISTRAR'S SIGNATURE: <u>Wm. E. Martin</u>	24. FUNERAL DIRECTOR: <u>Wm. E. Martin</u>	ADDRESS: <u>Highville, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. P.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

278

## CERTIFICATE OF DEATH

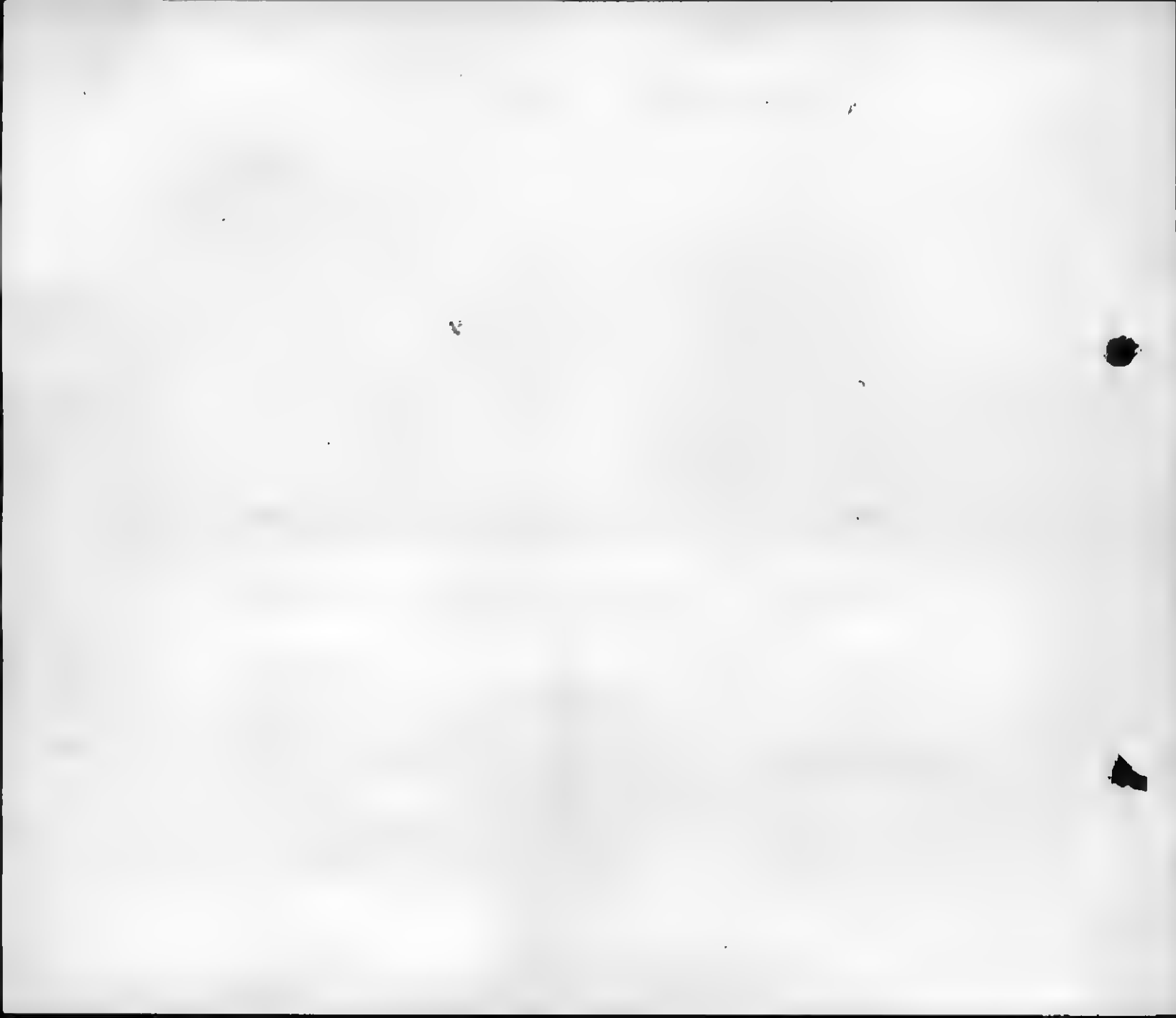
Reg. Dist. No.

37

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cabinville</u>		LENGTH OF STAY (in this place) <u>2 yrs. 6 m. 15 d.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
TOWN <u>Cabinville</u>				TOWN <u>Marley Park, Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural give nearest town) <u>Marley Park, Md</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Nellie C Green</u>				<u>1 30 1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>W.</u>	8. DATE OF BIRTH. <u>4/15/89</u>	9. AGE last birthday: <u>66</u> yrs	10. UNDER 1 YEAR: Months	11. UNDER 24 HRS: Days	12. UNDER 1 MIN: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Spinner</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Wilbur Martin</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
14. MOTHER'S MAIDEN NAME: <u>Ella</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>—</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>?</u>			
17. INFORMANT & ADDRESS: <u>Spring Grove Hospital records</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>5 days</u>	
DUE TO							
ANTECEDENT CAUSE (B) <u>Hypertensive C.V. disease</u>						<u>unknown</u>	
DUE TO							
(C) <u>Pneumonia; Bronch</u>						<u>3 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 15</u> , 19 <u>53</u> , to <u>Jan 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 30</u> , 19 <u>56</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS <u>Spring Grove State Hosp</u>		DATE SIGNED <u>1-30-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>		LOCATION (City, town, or county) (State) <u>Hampton</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-1-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Paul E. [Signature]</u>		ADDRESS <u>3615-7 Chestnut Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00266

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

279

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>BALTIMORE</b>		STATE <b>MARYLAND</b>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>FORT HOWARD</b>		<b>8 Days</b>		TOWN <b>BALTIMORE</b>		<b>3Y01-4</b>	
HOSPITAL OR INST TUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>1916 PATTERSON PARK AVENUE</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<b>WILLIAM GREENBORN</b>				<b>January 6 1956</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>MALE</b>	<b>WHITE</b>	<b>MARRIED</b>	<b>January 4, 1894</b>	<b>62</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Pump Man</b>		<b>Beth. Steel Co.</b>		<b>Baltimore, Maryland</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Gustav Greenborn</b>				<b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>Yes</b>		<b>WW-1</b>		<b>212-05-2750</b>			
				<b>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
4. IMMEDIATE CAUSE (A) <b>CORONARY OCCLUSION</b>						<b>1 HOUR</b>	
ANTECEDENT CAUSE(S) DUE TO <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b>						<b>UNKNOWN</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <b>HYPERTENSIVE CARDIO-VASCULAR DISEASE</b>						<b>UNKNOWN</b>	
(C) <b>CONGESTIVE HEART FAILURE</b>						<b>UNKNOWN</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that <b>VA</b> attended the deceased from <b>Dec. 29, 1955</b> to <b>Jan. 6, 1956</b> and that death occurred at <b>2:35 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>W. A. HALL</b>				ADDRESS (Street, city, town, state) <b>VAH, Fort Howard, Maryland</b>		DATE SIGNED <b>1-7-56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Jan. 10, 1956</b>		<b>Baltimore National Cemetery</b>		<b>Baltimore, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>Jan. 10, 1956</b>				<b>ULLRICH FUNERAL HOME</b>		<b>4210 Belair Rd., Baltimore, Md.</b>	

BUREAU V. S.

JAN 11 1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>MD.</b>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X TOWN Md.</b>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Spawover Point</b>		STREET ADDRESS (If rural, give location) <b>3715 Towanda Ave</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>DAVID Morris GREENFIELD</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>1-13 1956</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <b>married</b>	8. DATE OF BIRTH: <b>Dec 18, 1904</b>
9. AGE last birthday: <b>51</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Steel Company</b>	
11. BIRTHPLACE (State or foreign country): <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME: <b>416 Sol Greenfield</b>		14. MOTHER'S MAIDEN NAME: <b>Pauline June</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY No.:	
17. INFORMANT'S ADDRESS: <b>William Greenfield - 2240 Linden Ave</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <b>ARTERIOSCLEROTIC CARDIO- DUE TO VASCULAR DISEASE</b>		
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO		
stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

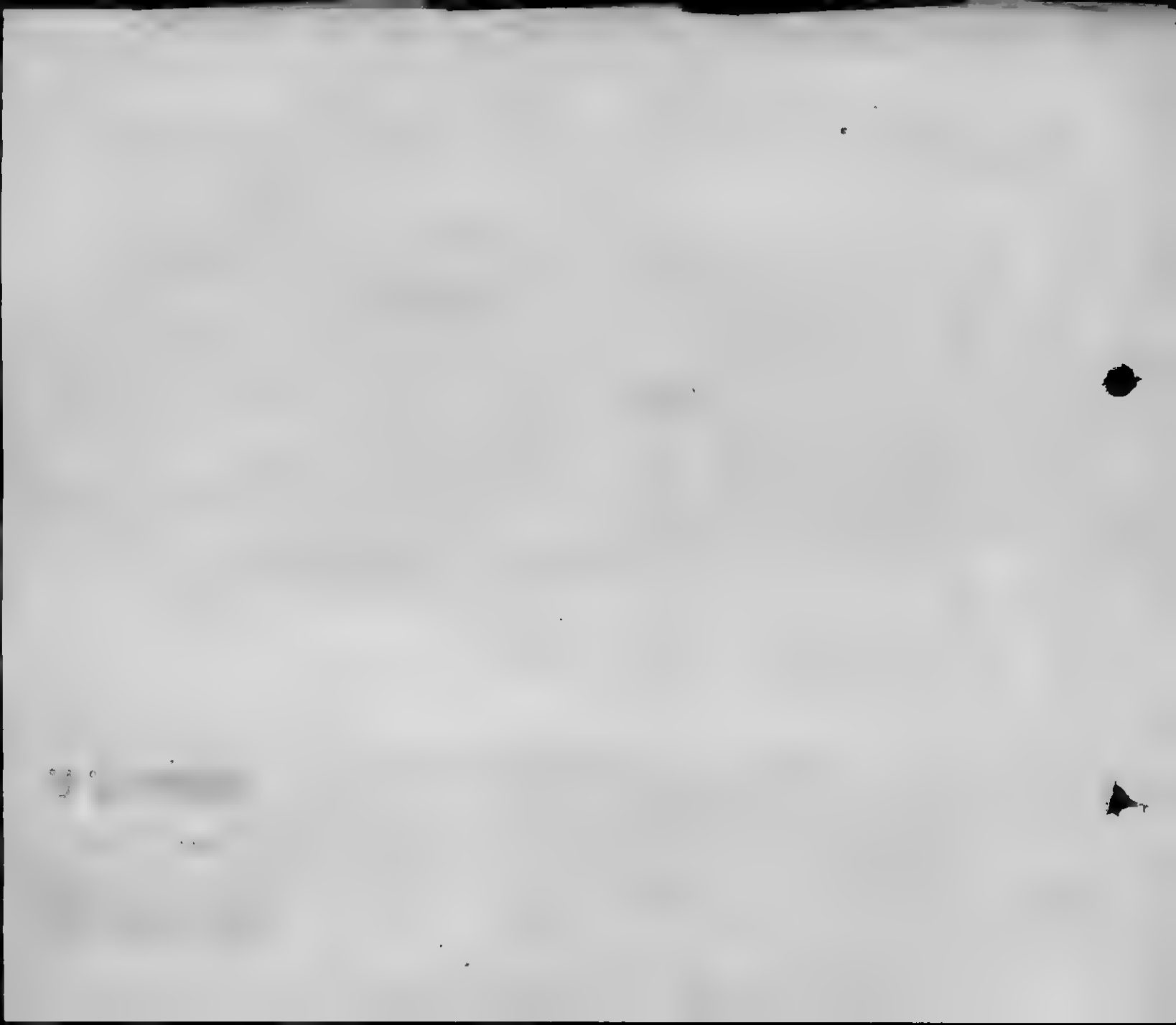
22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE **Paul F. Merin** CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **1-14-56**  
 DEPUTY MEDICAL EXAMINER ☐  
 M. D. ASSISTANT MEDICAL EXAM. ☒

23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>	DATE THEREOF: <b>Jan 15/56</b>	NAME OF CEMETERY OR CREMATORY: <b>Chesapeake Ammono</b>	LOCATION (City, town, or county) (State): <b>Baltimore, Md</b>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE: <b>Jan 15 1956</b>		24. FUNERAL DIRECTOR'S ADDRESS: <b>1124-26 W. North Ave</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



281

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>34 Days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>2419 Arunah Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>BOOKERT</u> (First) <u>W.</u> (Middle) <u>GRIER</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>January 5</u> <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>August 4, 1918</u>	9. AGE last birthday <u>37</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Waynesboro, S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Clinton Grier</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Lightner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u> <u>VV II</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>249-05-2181</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						2 YEARS	
IMMEDIATE CAUSE (A) <u>DISEMINATED LUPUS ERYTHEMATOSIS</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 2</u> , 19 <u>55</u> , to <u>Jan. 5</u> , 19 <u>56</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Donald D. Mark</u>				ADDRESS (Street, city, town, state) <u>M.D. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>1-6-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-10-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dawson L. Fisher</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L. Russ</u>		ADDRESS <u>2222 W. North Ave., Balto. Md.</u>	
DATE							

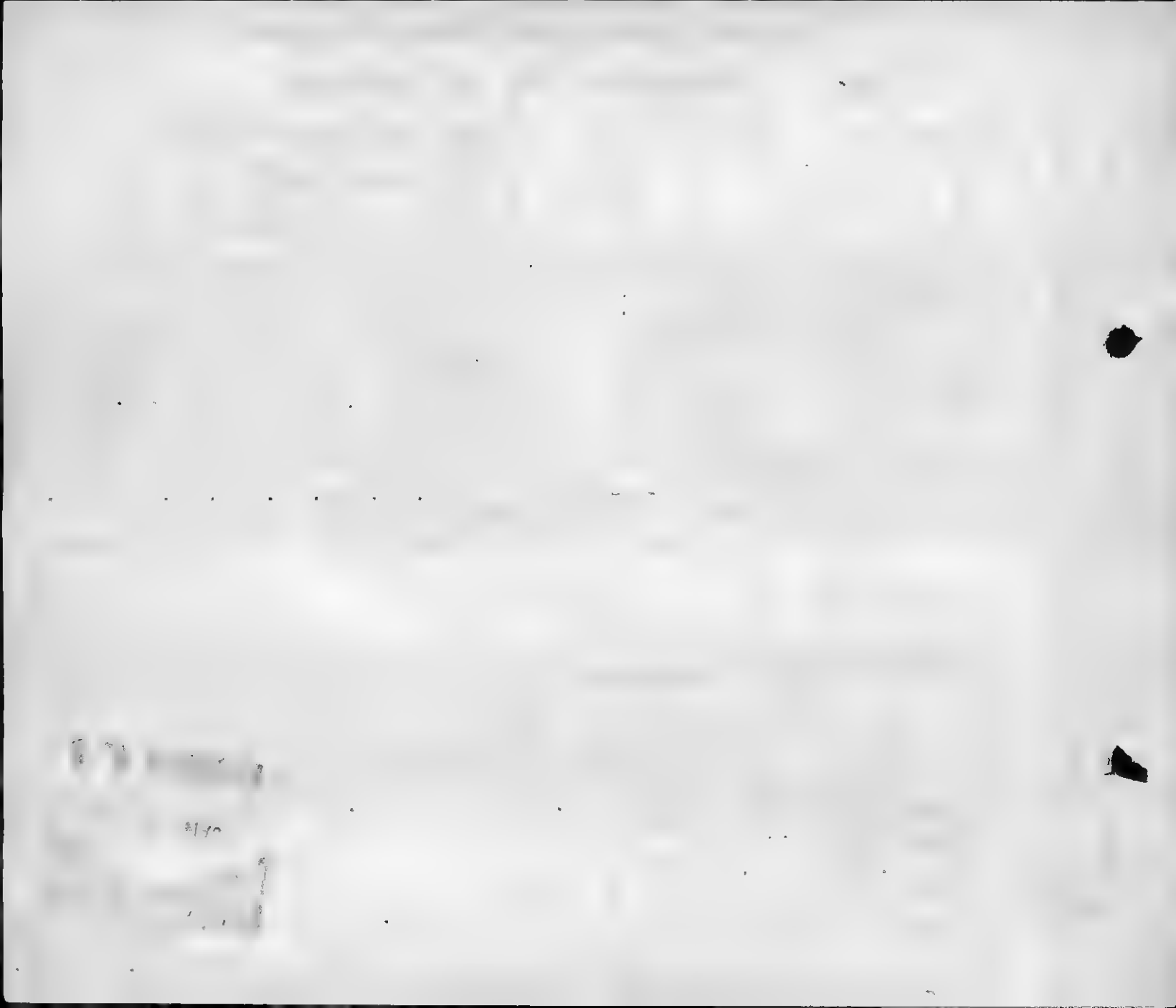
INSTRUCTIONS

**1** **INSTRUCTIONS:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



282

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

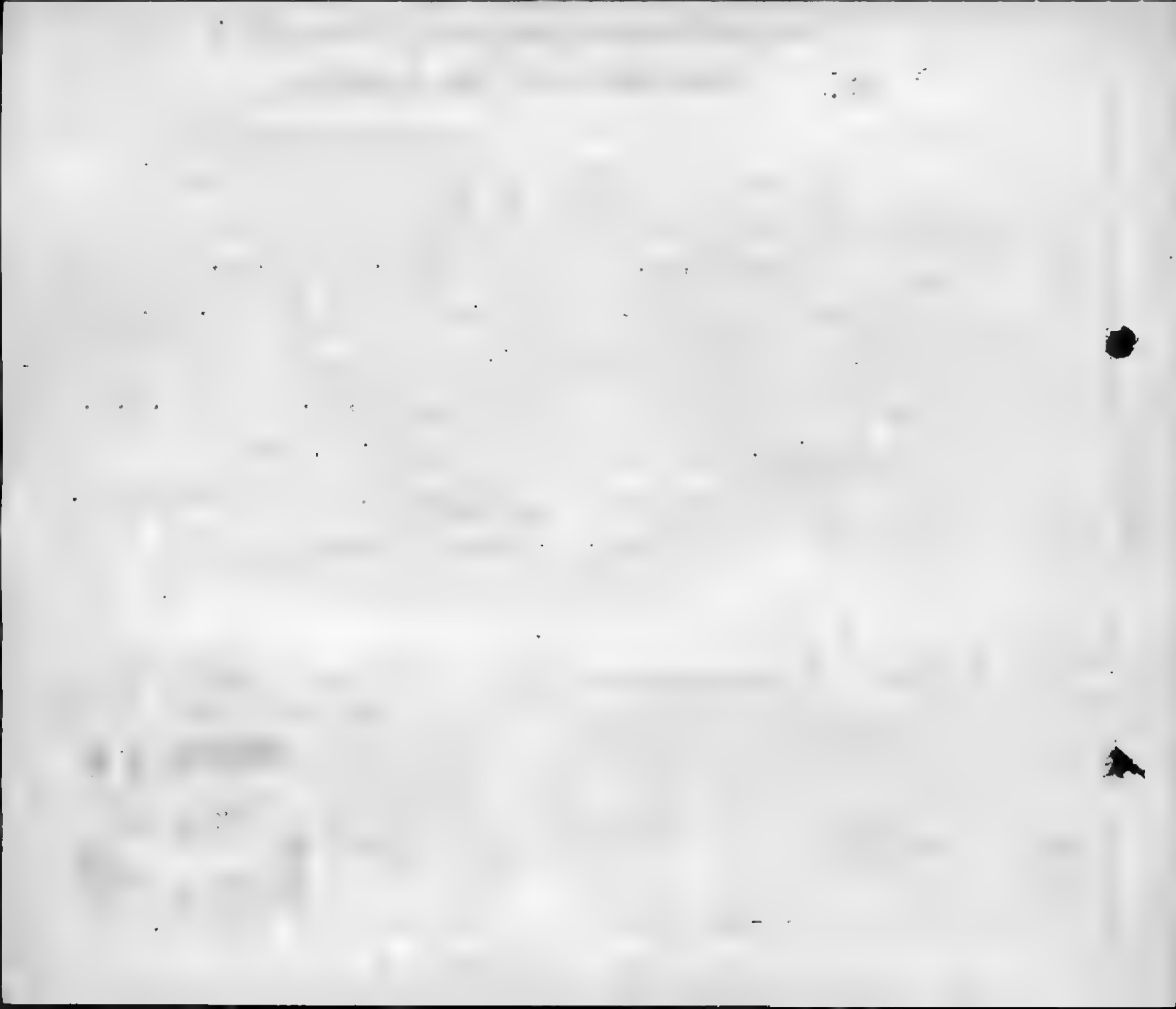
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>White Marsh</u>		Life		TOWN <u>White Marsh</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>White Marsh, Md.</u>				STREET ADDRESS (If rural give location) <u>White Marsh, Md.</u>			
3. NAME OF (First) (Middle) (Last) <u>Anne Louise Grimm</u> (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 9, 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 13, 1945</u>	9. AGE last birthday <u>10</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>White Marsh, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Francis O. Grimm</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Cogle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Francis O. Grimm White Marsh, Md.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Postinfectious Encephalopathy</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Probably Pertussis</u>				<u>3 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1, 1956</u> , to <u>Jan. 9, 1956</u> , that I last saw the deceased alive on <u>Jan. 9, 1956</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Hatterman</u> M.D.				DATE SIGNED <u>1/11/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-12-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Morgland Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>Dr. Hatterman</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lashan Funeral Home - 7401 Belair Rd.</u>		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M





MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

283

CERTIFICATE OF DEATH

00270

Reg. Dist. No. 31

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		LENGTH OF STAY (in this place) <u>4 yrs</u>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1924 Gwynn Oak Ave</u>				STREET ADDRESS (If rural give location) <u>1924 Gwynn Oak Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>Anna E. Grimmer</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 23 1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 10, 1903</u>	9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hutzlers</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Kurtz</u>				14. MOTHER'S MAIDEN NAME <u>Emma</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-03-6134</u>		17. INFORMANT & ADDRESS <u>Mr. Raymond Grimmer, 1924 Gwynn Oak Ave</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>Coronary Occlusion -</u>						<u>1 day -</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute Congestive Heart Failure -</u>						<u>2 mos -</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Congestive Heart Disease</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>gold. Rheumatic fever -</u>						<u>45 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 23, 1956</u> to <u>Jan 23, 1956</u> , that I last saw the deceased alive on <u>Jan 23, 1956</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thomas E. Wheeler</u>		ADDRESS (Street, city, town, state) <u>M.D. 3601 Clyman Rd - Baltimore</u>		DATE SIGNED <u>1/23/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Jan. 26/56</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 26, 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. Thos. E. Wheeler</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Witke</u>		ADDRESS <u>4101 Edmondson Ave.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1515 1-55 10M

NEW YORK

AN 1956

RECEIVED

284

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b> MARYLAND		STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Towson</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Towson</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1642 Yakona Road</b>		STREET ADDRESS (If rural give location) <b>1642 Yakona Road</b>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<b>CATHERINE ELIZABETH GROOM</b>		<b>January 25, 1956</b>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
<b>Female</b>	<b>White</b>	<b>Married</b>	<b>October 7, 1873</b>
9. AGE last birthday		10. AGE last birthday	
<b>82 yrs.</b>		<b>82 yrs.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country): <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>George W. Wilson</b>		14. MOTHER'S MAIDEN NAME: <b>Christine Sellars</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>No</b>		16. SOCIAL SECURITY NO.: <b>None</b>	
17. INFORMANT & ADDRESS: <b>Harry Groom, 1642 Yakona Rd., Towson, Md.</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Carcinoma of common bile duct</b>		<b>3 mos</b>	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>1/15</b> , 1954, to <b>1/25</b> , 1956, that I last saw the deceased alive on <b>1/15</b> , 1956, and that death occurred at <b>10 A</b> M, from the causes and on the date stated above.			
SIGNATURE <b>Harry Groom</b>		DATE SIGNED <b>1/26/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		24. FUNERAL DIRECTOR ADDRESS <b>John Burns' Sons, Towson, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Jan. 28, 1956</b>		REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DUNN V. S.

JAN

1952

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar **within 48 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

285

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard, Md.</u>		<u>49 Days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>827 Washington Boulevard</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>GEORGE H. GROSS</u>				<u>January 3, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>April 27, 1892</u>	<u>63</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grain</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George H. Gross</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Slicker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>CHRONIC ARTERIOSCLEROTIC NEPHRITIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 YEARS</u>	
ANTECEDENT CAUSE(S) DUE TO <u>HYPERTENSION</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CONGESTIVE HEART FAILURE</u>						3 MONTHS	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from Nov. 15, 1955, to Jan. 3, 1956, and that death occurred at 1:40 P.M. from the causes and on the date stated above.</b> SIGNATURE <u>Donald D. Mark, M.D.</u> ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>1-4-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/6/56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>1/5/56</u>		REGISTRAR'S SIGNATURE <u>W. H. Cook-Blight, Inc.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Cook-Blight, Inc.</u> ADDRESS <u>6009 Harford Rd. Balto. Md.</u>			

SHIRAZ V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

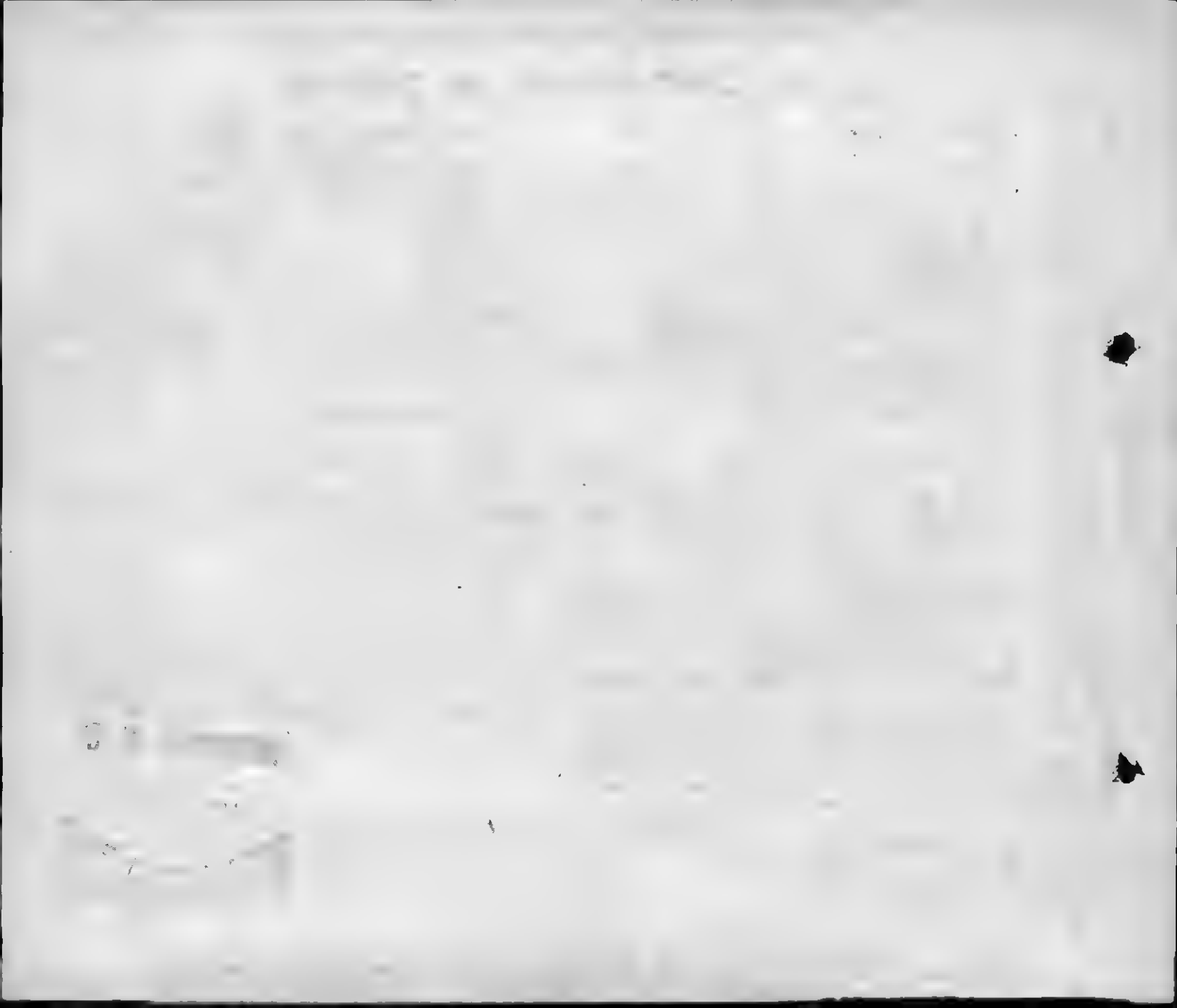
286

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Balto.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cockeysville</u>		<u>Life</u>		TOWN <u>Cockeysville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>Bosley Ave</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Rebecca Virginia Haines</u>				DEATH <u>1</u> <u>31</u> <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Dec. 13, 1872</u>	<u>83</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Hedrick</u>				<u>Mary Funk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>---</u>		<u>Mrs Fred Smith Bosley Ave, Cockeysville</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				II. MEDICAL CERTIFICATION			
422. IMMEDIATE CAUSE (A)				Coronary Thrombosis			
ANTECEDENT CAUSE(S) DUE TO				Myocardial Regeneration			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/30/1955</u> to <u>1/30/1956</u> , that I last saw the deceased alive on <u>1/30/1956</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Dr. K. E. ...</u>		<u>---</u>		<u>TIMOTHY</u>		<u>1/31/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-2-56</u>		<u>Poplar Methodist</u>		<u>Cockeysville Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>2 Feb 1956</u>		<u>Ann ...</u>		<u>L. Scott ...</u>		<u>Shades Md.</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be delivered for use as a burial transit permit.





## CERTIFICATE OF DEATH

Reg. Dist. No. 43

287

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Overlea</u>		<u>7 Months</u>		TOWN <u>Overlea</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Madeline Ave.</u>				STREET ADDRESS (If rural give location) <u>14 Madeline Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Flora</u> (Middle) <u>Gay</u> (Last) <u>Hamric</u>				(Month) <u>January</u> (Day) <u>10</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Nov. 4, 1873</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>At Home</u>		<u>West Virginia</u>		<u>U. S. A.</u>	
13. FATHER'S NAME <u>Isaac Boggs</u>				14. MOTHER'S MAIDEN NAME <u>Mary Garey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>None</u>		<u>Henry D. Parks 14 Madeline Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>4 hours.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>						<u>many years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June, 19 55</u> , to <u>Jan 10, 19 56</u> , that I last saw the deceased alive on <u>Jan 10, 19 56</u> , and that death occurred at <u>7:08 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Max R. English</u>		M.D. <u>5713 Belair Rd.</u>		ADDRESS (Street, city, town, state) <u>Baltimore</u>		DATE SIGNED <u>1-10-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>1-10-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Slamps</u>		LOCATION (City, town, or county) (State) <u>Sugar Grove, Va.</u>	
24. RECEIVED BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. L. L. Reifneider</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
DATE <u>Jan. 11, 1956</u>							

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

283

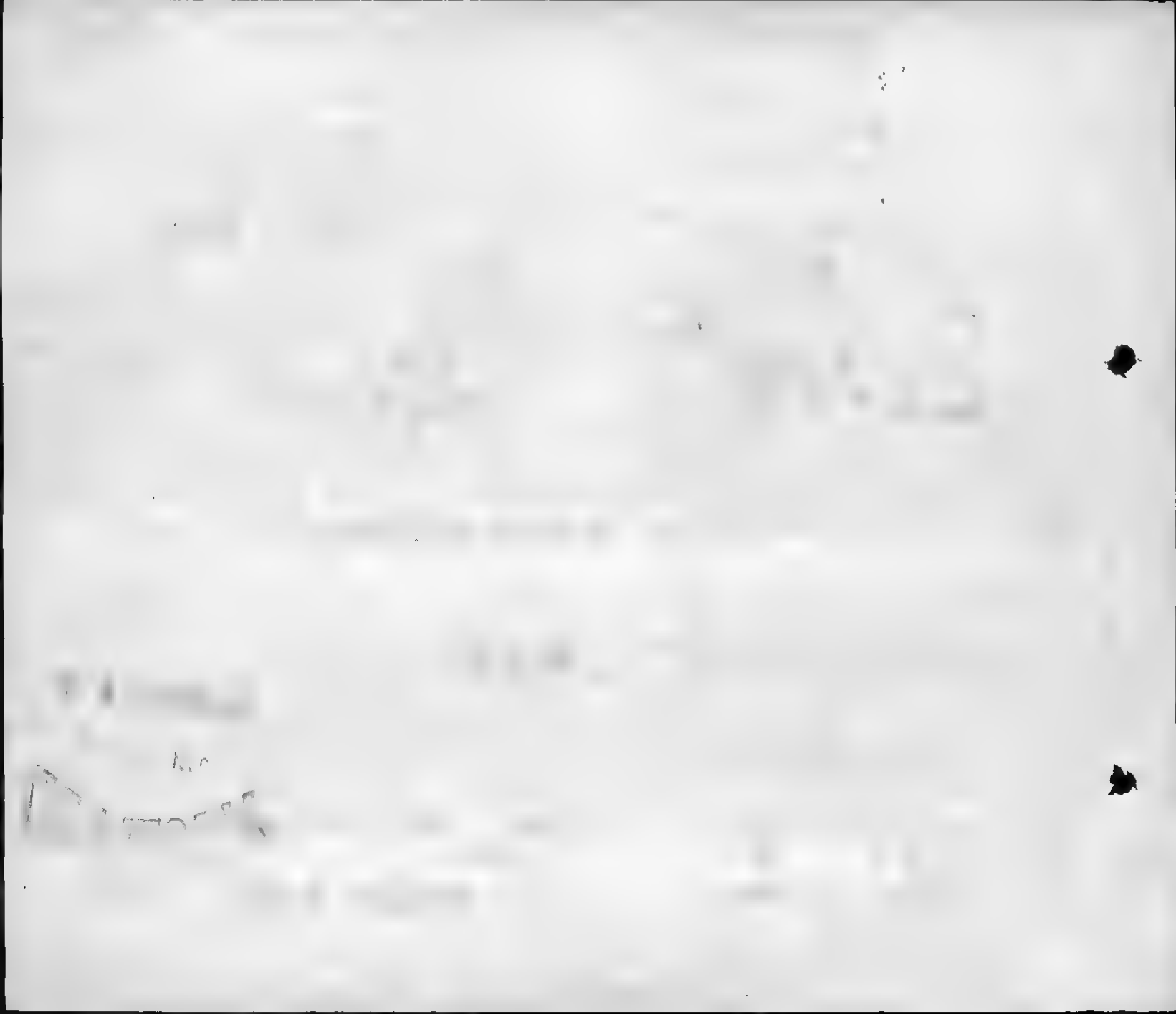
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00275

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Id</u>		COUNTY <u>Prince Georges Co</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Columbia 28</u>		LENGTH OF STAY (in this place) <u>Since July 14, 1953</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington 19</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hospital</u>				STREET ADDRESS (If rural give location) <u>9, Delano Drive</u>			
3. NAME OF DECEASED. (Type or Print)				4. DATE OF DEATH.			
(First) <u>HAZEL</u> (Middle) <u>C</u> (Last) <u>HARDY</u>				(Month) <u>1</u> (Day) <u>21</u> (Year) <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Married</u>		8. DATE OF BIRTH. <u>1. 10. 1902</u>	
9. AGE last birthday <u>54</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles A. Gray</u>				14. MOTHER'S MAIDEN NAME: <u>Mary F. Willis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>331</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
<u>260X</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Diabetes</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7. 14</u> , 1953, to <u>1. 21</u> , 1956 that I last saw the deceased alive on <u>1. 21</u> , 1956, and that death occurred at <u>12. 10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Rena Becker</u>				ADDRESS <u>Spring Grove Hospital</u>		DATE SIGNED <u>1/21/56</u>	
23. BURIAL, CREMATION, REMOVAL. (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>Jan 24-56</u>		<u>Cedar Hill</u>		<u>Leesylvania Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan 21-56</u>		<u>T.E. Harry</u>		<u>Demmons Bros. 1661-1663</u>		<u>4401 Hyatt Rd SE Washington, DC</u>	



289

## CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write TOWN and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write TOWN and give nearest town)	
<u>TOWN Harrison</u>	<u>45 yrs.</u>	<u>TOWN Harrison</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last) <u>Robert Barker Harrison Sr.</u>		OF DEATH <u>JAN. 17 1956</u>	
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Jan 14 1878</u>
9. AGE last birthday: <u>77</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Insurance</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Thomas B Harrison</u>	
14. MOTHER'S MAIDEN NAME: <u>Mary Williams</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>220-30-4966</u>		17. INFORMANT & ADDRESS: <u>Mrs Robert B. Harrison Sr.</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>		<u>5 yrs.</u>	
ANTECEDENT CAUSE (B) <u>DUE TO</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1957</u> , to <u>17 Jan, 1956</u> , that I last saw the deceased alive on <u>17 Jan, 1956</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Paul H. Royce M.D.</u>		ADDRESS <u>Pikesville 8 Ind</u>	
DATE SIGNED <u>17 Jan 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>Jan. 19, 1956</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>St. Thomas Cemetery</u>		<u>Harrison, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>Jan. 18, 1956</u>		<u>Archie A. Newell</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Frank D. Daniel</u>		<u>Pikesville</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. A. DAVENPORT

CITY OF



## MARYLAND STATE DEPARTMENT OF HEALTH

00277

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

Item 7, Film 3191 1-16-56 et

1. PLACE OF DEATH— COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <u>Baltimore</u> COUNTY <u>Md.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Spawons Point, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>7352 Hughes Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spawons Pt. Hosp.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Glenn H. Heffner</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>9</u> (Year) <u>1956</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 29, 1924</u>
9. AGE last birthday <u>32</u> yrs.		10. If under 1 year: Months <u>8</u> Days <u>18</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Svc Co</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William T. Heffner</u>		14. MOTHER'S MAIDEN NAME <u>William A. Warfel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Edhel B. Heffner, Sp. Pl. Md.</u>	

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

Crush Injury to Left Pelvis

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Disruption at SymphysisInternal Injuries to Lower Left Abdomen

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING ☐

## PLACE (Home, farm, factory, street, office, etc.) OF INJURY

## (CITY OR TOWN)

## (COUNTY)

## (STATE)

## TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

## HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐

## SIGNATURE

(Degree or title)

## ADDRESS

## DATE SIGNED

## 23. BURIAL, CREMATION OR REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6400 Mornington Rd.

Drum Lake.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00278

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		STATE <u>Md</u> COUNTY <u>Balto</u>		CITY (if outside corporate limits, write RURAL and give nearest town) <u>Balto</u>		TOWN <u>Balto</u>	
CITY (if outside corporate limits, write RURAL and give nearest town) <u>Kriston</u>		LENGTH OF STAY (in this place) <u>2 wks</u>		STREET ADDRESS (if rural give location) <u>5601 Whinner Ave</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Nursing Home Sorensen</u>	
3. NAME OF DECEASED (Type or Print) <u>Ernest R. Helmrich</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1-20 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>R</u>	8. DATE OF BIRTH <u>Apr 24 1899</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Mln. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman Royal Crown Bottling</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto</u>		11. BIRTHPLACE (State or foreign country) <u>W. S. A.</u>		12. CITIZEN OF WHAT COUNTRY <u>W. S. A.</u>	
13. FATHER'S NAME <u>Henry Helmrich</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Runk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u></u> (If Yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>213-10-4219</u>		17. INFORMANT & ADDRESS <u>Thomas R. Waeche 5601 Whinner Ave</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
410X IMMEDIATE CAUSE (A) <u>no</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>no</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>cardiac asthma severe</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Myocarditis chronic</u>							
19a. DATE OF OPERATION <u>no</u>		19b. MAJOR FINDINGS OF OPERATION <u>no</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no injury</u>		21b. PLACE (Home, farm, factory, of injury, street, office bldg., etc.) <u>no injury</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>no injury</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>no injury</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> F. <input type="checkbox"/> <u>no injury</u>		21f. HOW DID INJURY OCCUR? <u>no injury</u>			
22. I hereby certify that I attended the deceased from ..... 19....., to ..... 19....., that I last saw the deceased alive on ..... 19....., and that death occurred at ..... M., from the causes and on the date stated above.							
SIGNATURE <u>Jamies Graham Martin</u> M.D.				ADDRESS (Street, city, town, state) <u>Balto Md</u>		DATE SIGNED <u>Jan 24 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-23-56</u>		NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
24. REC'D BY REGISTRAR <u>Jan 24 1956</u>		REGISTRAR'S SIGNATURE <u>Michael Guy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Faring Byers</u>		ADDRESS <u>5005 Pk. Hyattsville Balto 15, Md</u>	

BUREAU OF

1 25 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Woodlawn</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<b>18 Summerfield Rd.</b>		STREET ADDRESS (If rural give location) <b>18 Summerfield Rd.</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<b>Martin J. Hendricks</b>				<b>Jan. 30 1958</b>			
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>		8. DATE OF BIRTH: <b>April 19, 1894</b>	
9. AGE last birthday: <b>61</b> yrs		IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS: Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Traffic Mgr. Cons. Cold Storage</b>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Washington, D. C.</b>	
13. FATHER'S NAME: <b>Martin J. Hendricks</b>				14. MOTHER'S MAIDEN NAME: <b>Mary Leahy</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <b>Yes WWI</b>				17. INFORMANT & ADDRESS: <b>Frieda Hendricks - 18 Summerfield Rd.</b>			
16. SOCIAL SECURITY NO.							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE: <b>53X</b>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(A) <b>Chronic Myocarditis</b>						<b>2 weeks</b>	
(B) <b>Metastatic Hepatic Adenocarcinoma</b>						<b>4/11/58</b>	
(C) <b>Carcinoma of Esophagus, Colon</b>						<b>6 weeks</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>C.P.C. Kidney with anemia</b>						<b>3 days</b>	
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Oct 15, 1942</b> to <b>Jan 30, 1958</b> that I last saw the deceased alive on <b>Jan 26, 1958</b> , and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
						<b>Jan 31, 1958</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Entombment</b>		<b>Feb. 2, 1958</b>		<b>Lorraine Mausoleum</b>		<b>Baltimore, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
				<b>Ellsworth Armacost - 4600 Liberty Hgts. Ave. 7</b>			



1

293

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Rural-Parkton 20 yrs.</u>		TOWN <u>Rural-Parkton.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Old York Rd.</u>		<u>Old York Rd.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<u>Rhoda E. Hershner</u>		<u>Jan. 6, 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Sept. 9, 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>Housewife</u>		<u>Own home.</u>	<u>Railroad, Pa. U.S.A.</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Wm S. Brose.</u>		<u>Emma J. Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>Calvin M. Hershner, Parkton, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary sclerosis</u>			<u>1 yr</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chr. interstitial Nephritis</u>			<u>10 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept. 1, 1955</u> to <u>Jan. 6, 1956</u> , that I last saw the deceased alive on <u>Jan. 5, 1956</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Paul E. Shaul</u>		ADDRESS (Street, city, town, state) <u>Shrewsbury, Pa.</u>	
DATE <u>Jan 9 1956</u>		DATE SIGNED <u>1-8-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 9 1956</u>	<u>Shrewsbury Lutheran</u>	<u>Shrewsbury, York Co, Pa.</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
	<u>Mrs. Howard Markham</u>	<u>James Parkton, New Freedom, Pa.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-10M



## MARYLAND STATE DEPARTMENT OF HEALTH

294

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH - COUNTY <u>Balto</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Balto</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springston Hosp 1-7-56</u>		STREET ADDRESS (If rural, give location) <u>3644 Langrock Rd Balto</u>	
3. NAME OF DECEASED (Type or Print) <u>Wilhelmina S Hilliard</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>7</u> (Year) <u>1956</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u>	8. DATE OF BIRTH <u>July 11, 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>91</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>John Hill</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
16. SOCIAL SECURITY No. <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Hempert</u>	
17. INFORMANT AND ADDRESS <u>Hospital records</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cardiac failure</u>			
Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u>			
(c) <u>Senility</u>			
11. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) <u>fracture left hip + knee</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Hospital</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Dec 27-55</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> No while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>fell on floor</u>		(CITY OR TOWN) (COUNTY) (STATE) <u>Catonsville Balto Md</u>	
22. I certify that I took charge of the remains described above, held an Autopsy Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Wm. Schieffer</u>		DATE SIGNED <u>1-5-56</u>	
23. BURIAL, CREMATION, DATE THEREOF (Specify) <u>Burial 1/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>	
LOCATION (City, town, or county) (State) <u>Balto., Md.</u>		24. FUNERAL DIRECTOR <u>Wm. J. Schieffer &amp; Sons</u>	
DATE REC'D BY LOCAL REG. <u>1/9/56</u>		ADDRESS <u>Balto 17 Md.</u>	

MAILED RESEVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





00282

## MARYLAND STATE DEPARTMENT OF HEALTH

Item 18 Film G192 2-8-56

295

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u> STREET ADDRESS (If rural, give location) <u>76 Edgewater Apts - Balto. 21, Md.</u>	
3. NAME OF DECEASED (Type or Print) <u>David</u> (First) <u>Allen</u> (Middle) <u>Hornwood</u> (Last)		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>23</u> (Year) <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>9-30-38</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>photography</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>17</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Julius Hornwood</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Landau</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Records Spring Grove State Hospital</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Congestive heart failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) due to unintentional(c) undetermined cause

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1/24/56

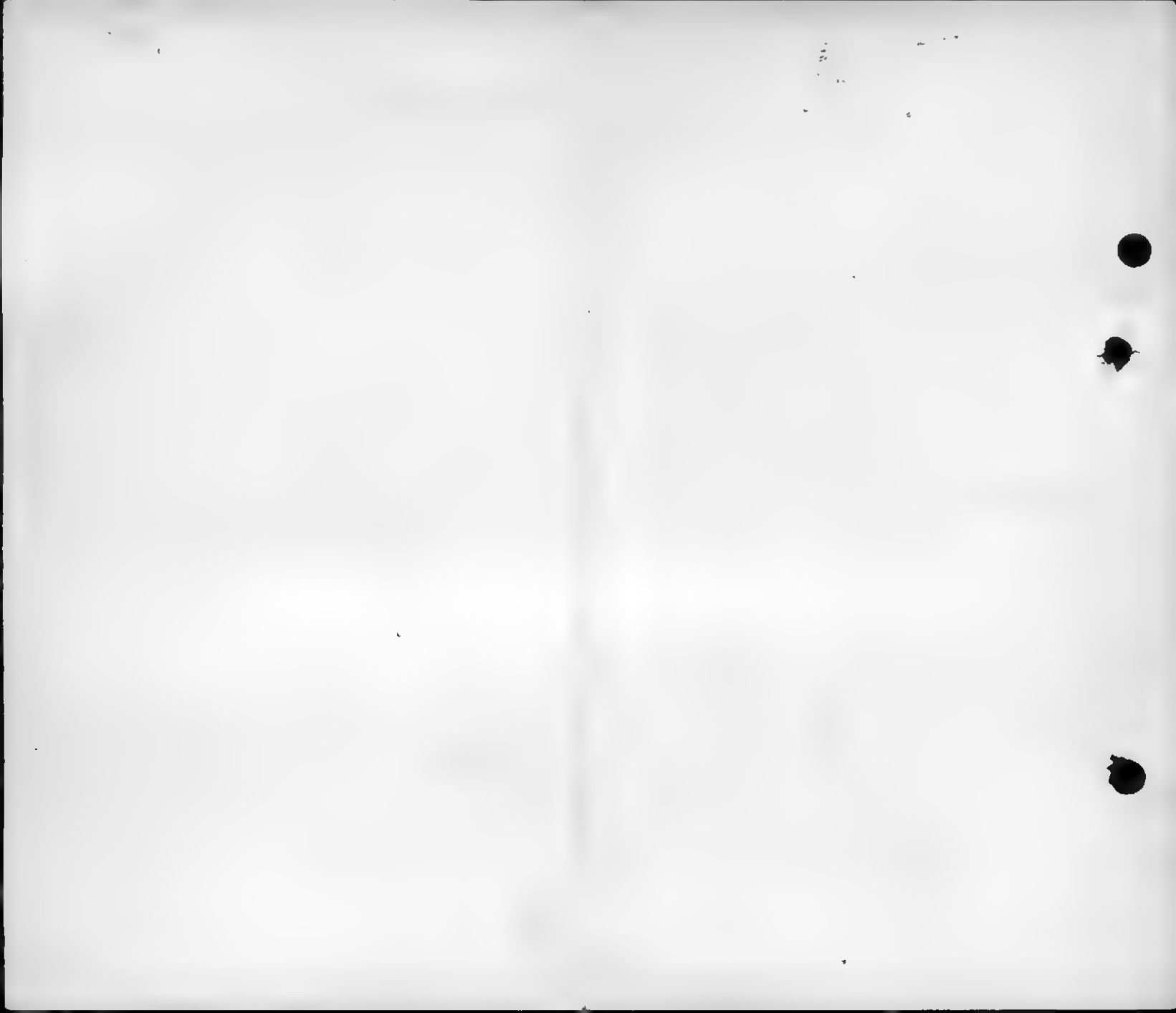
A. W. Hedrich

Wm. Cook Inc.

1217 St. Paul st.

MARGIN RESERVED FOR INDEXING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



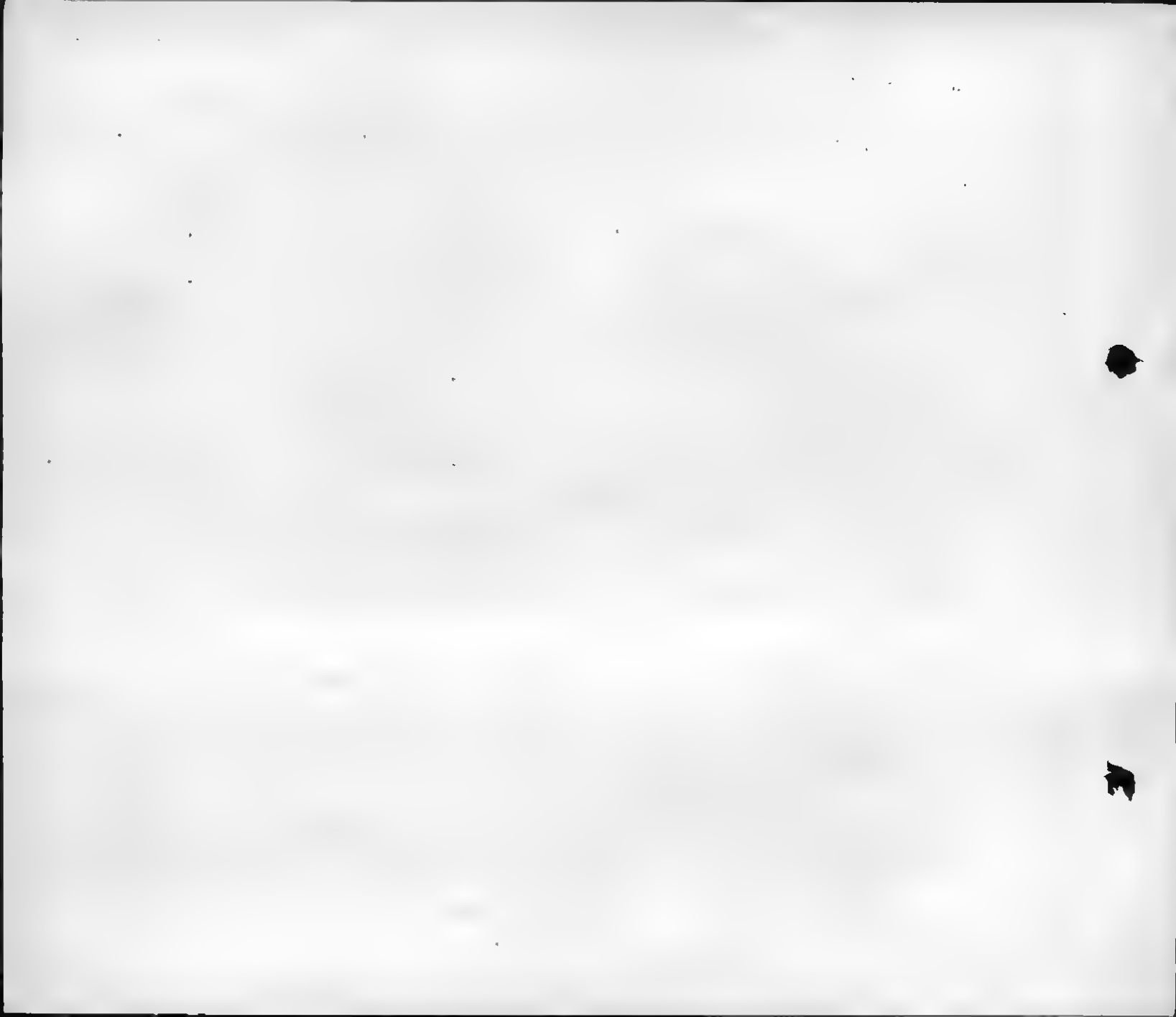
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00283

## 296 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:																		
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>																
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)																		
TOWN <u>Towson</u>				OR TOWN <u>Towson</u>																		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>614 Overbrook Rd.</u>				STREET ADDRESS (If rural give location) <u>614 Overbrook Rd.</u>																		
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:																		
<u>MARION S. HUBBARD</u>				<u>Jan. 27, 1956</u>																		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.															
<u>male</u>	<u>white</u>	<u>widowed</u>	<u>April 10, 1864</u>	<u>91</u>																		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:																		
<u>Salesman (Rtd)</u>				<u>Retail Shoes</u>																		
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:																		
<u>John Thomas Hubbard</u>				<u>Georgiana Coffin</u>																		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.																		
<u>no</u>				<u>212-14-2520</u>																		
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION																		
<u>Mrs. Elra M. Palmer - 614 Overbrook Rd.</u>				<table border="1"> <tr> <td colspan="2">I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</td> <td>INTERVAL BETWEEN ONSET AND DEATH</td> </tr> <tr> <td colspan="2">(A) IMMEDIATE CAUSE</td> <td><u>3-4 da.</u></td> </tr> <tr> <td colspan="2">(B) ANTECEDENT CAUSE (S)</td> <td><u>?</u></td> </tr> <tr> <td colspan="2">DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST</td> <td></td> </tr> <tr> <td colspan="2">(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</td> <td></td> </tr> </table>				I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	(A) IMMEDIATE CAUSE		<u>3-4 da.</u>	(B) ANTECEDENT CAUSE (S)		<u>?</u>	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH																				
(A) IMMEDIATE CAUSE		<u>3-4 da.</u>																				
(B) ANTECEDENT CAUSE (S)		<u>?</u>																				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST																						
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.																						
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?																		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?																		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?																		
22. I hereby certify that I attended the deceased from <u>Nov 27 1955</u> to <u>Jan 27, 1956</u> that I last saw the deceased alive on <u>Jan 20, 1956</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.																						
SIGNATURE <u>Lawrence J. Humaugh</u>		M. D. <u>3711 2nd Rd Balto 119nd</u>		DATE SIGNED																		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)																
<u>Burial</u>		<u>1/31/56</u>		<u>Olivet Cem.</u>		<u>St. Michaels, Md.</u>																
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS																
<u>1-30-56</u>		<u>L</u>		<u>Thm. J. Siskewitz</u>		<u>Sous. Balto 17 Md.</u>																



00284

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

297

## CERTIFICATE OF DEATH

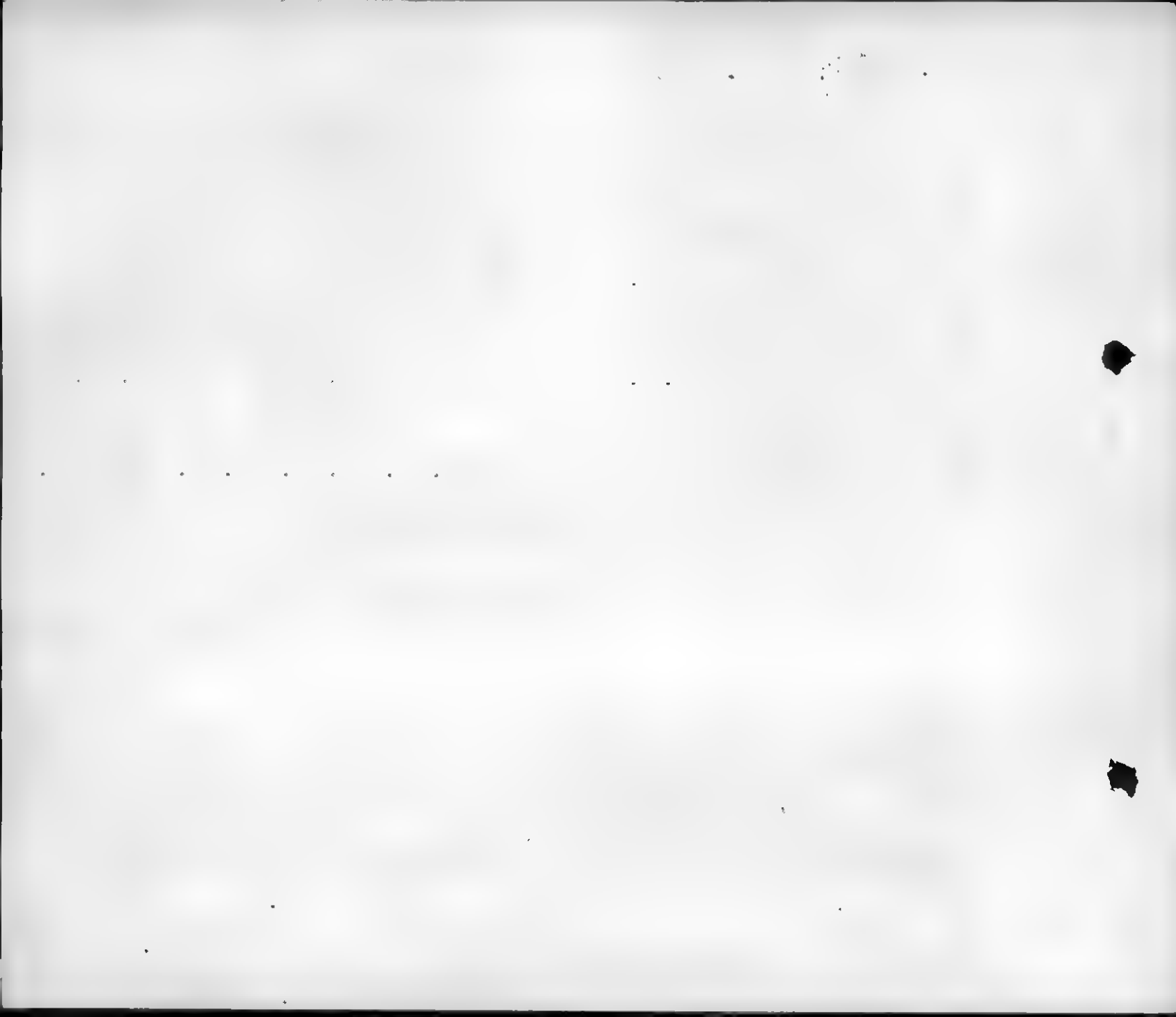
Reg. Dist. No. 6

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>3 days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1219 Urban Way</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>WILLIAM C. HUMPHRESS</u>				<u>January 22 1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>11/8/88</u>	
9. AGE last birthday: <u>67 yrs</u>		10. MONTHS: <u>22</u>		11. DAYS: <u>19</u>		12. HOURS: <u>56</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Soldier</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>U. S. Army</u>		11. BIRTHPLACE (State or foreign country): <u>Casey Creek, Kentucky</u>	
13. FATHER'S NAME: <u>Talbert Humphress</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Woolford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Yes WW II</u>				16. SOCIAL SECURITY NO: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
IMMEDIATE CAUSE (A) <u>CEREBROVASCULAR ACCIDENT</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>DIABETES MELLITUS</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that <u>Dr. A. H. Slasman</u> attended the deceased from Jan. 19, 1956, to Jan 22, 1956, that he saw the deceased <u>on Jan 22, 1956</u> and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. H. Slasman</u>				ADDRESS <u>Fort Howard, Md.</u>		DATE SIGNED <u>1/22/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/23/56</u>		REGISTRAR'S SIGNATURE <u>A. W. Friedrich</u>		24. FUNERAL DIRECTOR <u>Walter Dabrowski Funeral Home</u>		ADDRESS <u>1001-A Dundalk Ave., Balto 24, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00285  
298  
CERTIFICATE OF DEATH  
Reg. Dist. No. 32

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>GARRISON</u>		LENGTH OF STAY (in this place) <u>27 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>GARRISON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>REISTERSTOWN Rd.</u>				STREET ADDRESS (If rural give location) <u>REISTERSTOWN Rd. (RURAL)</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ROBERT LITTLE JAMES</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1-3-1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>12-1-1889</u>	
9. AGE last birthday <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Assistant Railroad Training School</u>		11. BIRTHPLACE (State or foreign country): <u>LONDON, ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Robert James</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Armstrong</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, not ink.) (If Yes, give war or dates) <u>British Army</u>				16. SOCIAL SECURITY NO. <u>MA 4 C. ARMSTRONG-WILSON, Md.</u>			
17. INFORMANT & ADDRESS.							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)		DUE TO <u>Chronic Myocarditis</u>		1 yr.			
ANTECEDENT CAUSE (B)		DUE TO <u>Hypertension</u>		10 yrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE OLD (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from JAN. 3 <sup>rd</sup> , 1956, to JAN. 3 <sup>rd</sup> , 1956, that I last saw the deceased alive on JAN. 3 <sup>rd</sup> , 1956, and that death occurred at 9:45 A.M. from the causes and on the date stated above.							
SIGNATURE <u>James G. Miller, M.D.</u>		ADDRESS <u>Pikesville, Md.</u>		DATE SIGNED <u>1/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>Jan. 6, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Wood Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>JAN 5, 1956</u>		REGISTRAR'S SIGNATURE <u>Harvey A. Newell</u>		24. FUNERAL DIRECTOR <u>Frank H. Newell</u>		ADDRESS <u>Pikesville</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1000

1000

1000



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

299

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

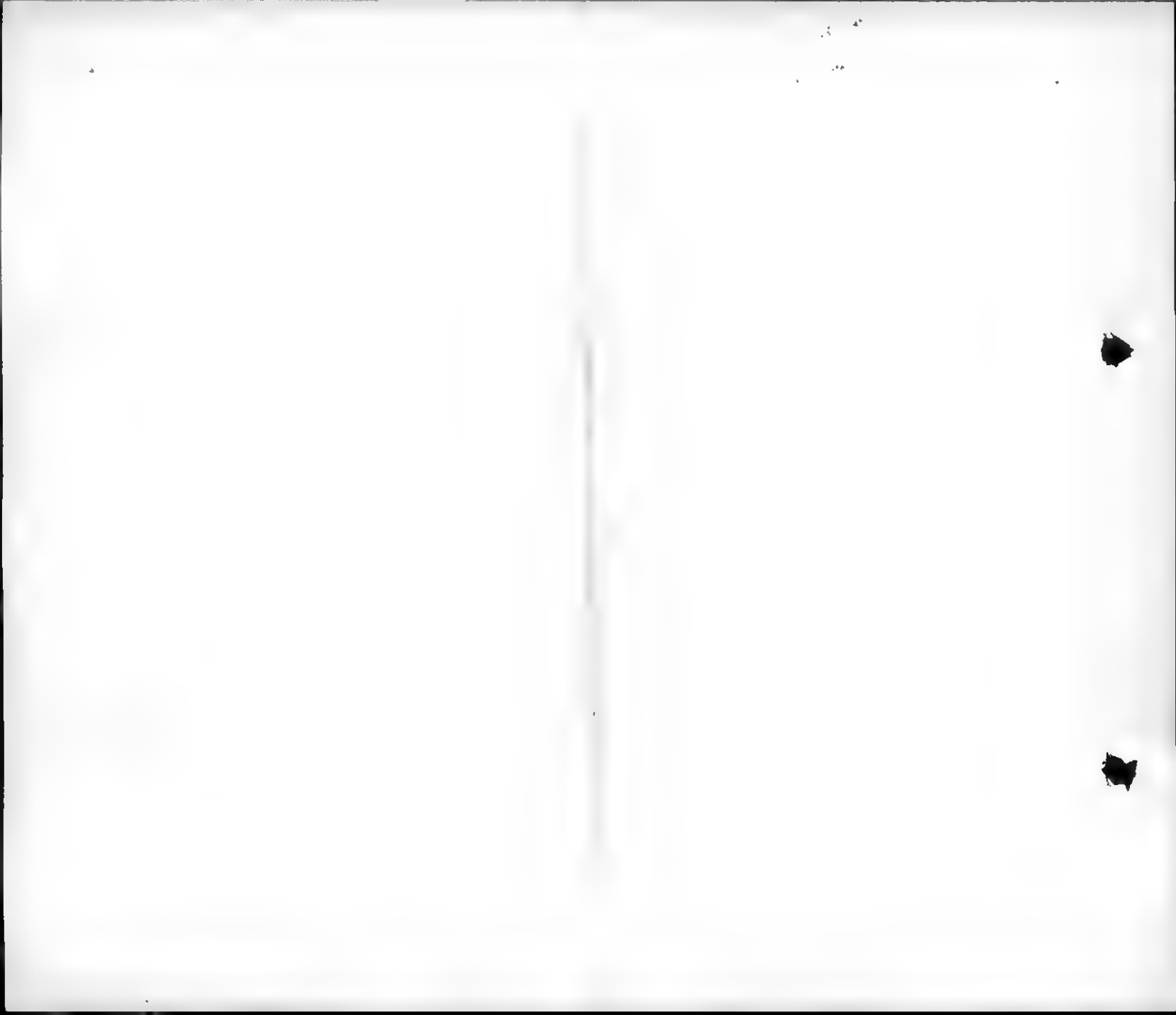
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Baltimore</b>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Rural-Pikesville</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Rural-Pikesville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Valley Forge Rd. Randallstown, Md.</b>		STREET ADDRESS (If rural give location) <b>Valley Forge Rd.-Randallstown, Md.</b>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <b>Stewart</b>	(Middle) <b>R.</b>	(Last) <b>Johnson</b>	(Month) <b>Jan.</b> (Day) <b>4,</b> (Year) <b>1956</b>
5. SEX. <b>Male</b>	6. COLOR OR RACE. <b>Colored</b>	7. SINGLE. MARRIED. <b>Married</b>	8. DATE OF BIRTH. <b>Jan. 14, 1910</b>
9. AGE last birthday <b>45</b> yrs.		10. AGE last birthday: IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Cemetery</b>	
11. BIRTHPLACE (State or foreign country): <b>Woodlawn, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Dennis Johnson</b>		14. MOTHER'S MAIDEN NAME: <b>Clara Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <b>Mrs. Clara Johnson-Valley Forge</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <b>Hypertensive C.V. disease - vessel</b>		<b>5 years -</b>
ANTECEDENT CAUSE (B) <b>Long illness - esp. chest</b>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C) <b>Pneumonia - pleural effusion - &amp; Pneumothorax</b>		<b>1 month.</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Congestive heart failure, acute</b>		<b>1 day -</b>
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>Jan. 24, 1955</b> , to <b>Jan. 4, 1956</b> , that I last saw the deceased alive on <b>Jan. 4, 1956</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.		
SIGNATURE <b>Stewart E. Caldwell</b>	ADDRESS <b>3601 Euphrates Rd. Baltimore</b>	DATE SIGNED <b>1-6-56</b>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>Jan. 7, 1956</b>	NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cem</b>
LOCATION (City, town, or county) <b>Baltimore Co., Md.</b>		(State)
DATE REC'D BY LOCAL REGISTRAR <b>Jan. 7, 1956</b>	REGISTRAR'S SIGNATURE <b>R.W.</b>	24. FUNERAL DIRECTOR <b>HOME</b> ADDRESS <b>HOLLAND FUNERAL - 1631 DRUID HILL AVE.</b>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		STATE <b>Maryland</b> COUNTY <b>Somerset</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Veterans Administration Hospital</b>		LENGTH OF STAY (in this place) <b>26 Days</b>		STREET ADDRESS (If rural give location) <b>RFD #1 Box 145</b>			
3. NAME OF (First) (Middle) (Last) <b>THOMAS JONES, JR.</b>				4. DATE (Month) (Day) (Year) <b>DEATH January 31 19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 4, 1922</b>	9. AGE last birthday <b>33</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oyster Shucker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster packing/ house</b>		11. BIRTHPLACE (State or foreign country) <b>Princess Anne, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Jones</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>220-12-2168</b>		17. INFORMANT & ADDRESS <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <b>SUBACUTE GLOMERULONEPHRITIS</b>						UNKNOWN	
2. ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <b>VA M.</b>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan. 5</b> , 19 <b>56</b> , to <b>Jan. 31</b> , 19 <b>56</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.							
DONALD D. MARK <i>D. Mark</i> M.D.				ADDRESS (Street, city, town, state) <b>VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>2/1/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>2/3/56</b>		NAME OF CEMETERY OR CREMATORY <b>Mount Vernon Cemetery</b>		LOCATION (City, town, or county) (State) <b>Mount Vernon, Maryland</b>	
24. REC'D BY REGISTRAR <b>DATE 2/3/56</b>		REGISTRAR'S SIGNATURE <i>William J. Law</i>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law, 802 Madison Ave., Baltimore, Md.</b>			

VS AISC 1-55 10M

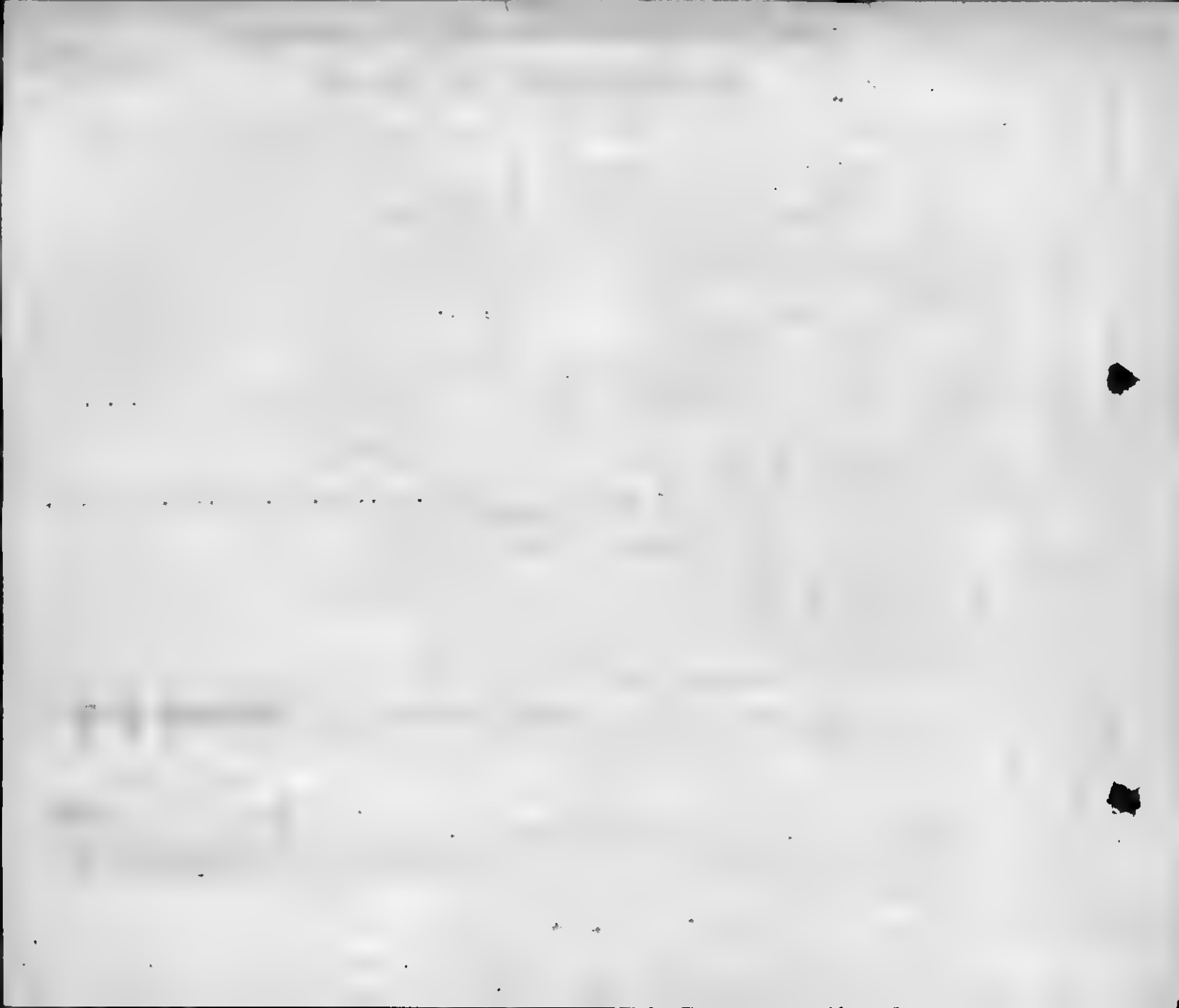
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

INSTRUCTIONS

Shipped to:

William James Funeral Home, Princess Anne, Md.



301

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Prince Georges</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>	LENGTH OF STAY (In this place) <b>2 1/2 yrs.</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Maryland</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Rosewood Training School</b>		STREET ADDRESS (If rural give location) <b>5604 30th Avenue</b>	
3. NAME OF DECEASED: (First) <b>Alan</b> (Middle) <b>Lee</b> (Last) <b>Josephson</b>		4. DATE OF DEATH: (Month) <b>1</b> (Day) <b>26</b> (Year) <b>19 56</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>	8. DATE OF BIRTH: <b>10/23/47</b>
9. AGE last birthday: <b>8</b> yrs.		10. UNDER 1 YEAR: Months <b>8</b> Days <b>26</b> Hours <b>19</b> Min.	11. BIRTHPLACE (State or foreign country): <b>Maryland</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>---</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>---</b>	
13. FATHER'S NAME: <b>Gilbert Cecil Josephson</b>		14. MOTHER'S MAIDEN NAME: <b>Rosalee Strasburger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT & ADDRESS: <b>Rosewood Records Owings Mills, Md.</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Broncho-Pneumonia</b>			<b>4 days</b>
ANTECEDENT CAUSE (B) <b>---</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <b>---</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Cerebral Spastic Paralysis</b>			<b>since birth</b>
19A. DATE OF OPERATION: <b>2</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>1/25/ 56</b> , to <b>1/26/ 56</b> , that I last saw the deceased alive on <b>1/26 19 56</b> , and that death occurred at <b>4:20 P.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Harry B. Butler</b>		ADDRESS <b>Owings Mills, Md.</b> DATE SIGNED <b>27 Jan 57</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		DATE THEREOF <b>Jan. 30, 1956</b>	
NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>1-29-56</b>		REGISTRAR'S SIGNATURE <b>Harry B. Butler</b>	
24. FUNERAL DIRECTOR <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 1 1956

BUREAU OF

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

302

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00289

CERTIFICATE OF DEATH

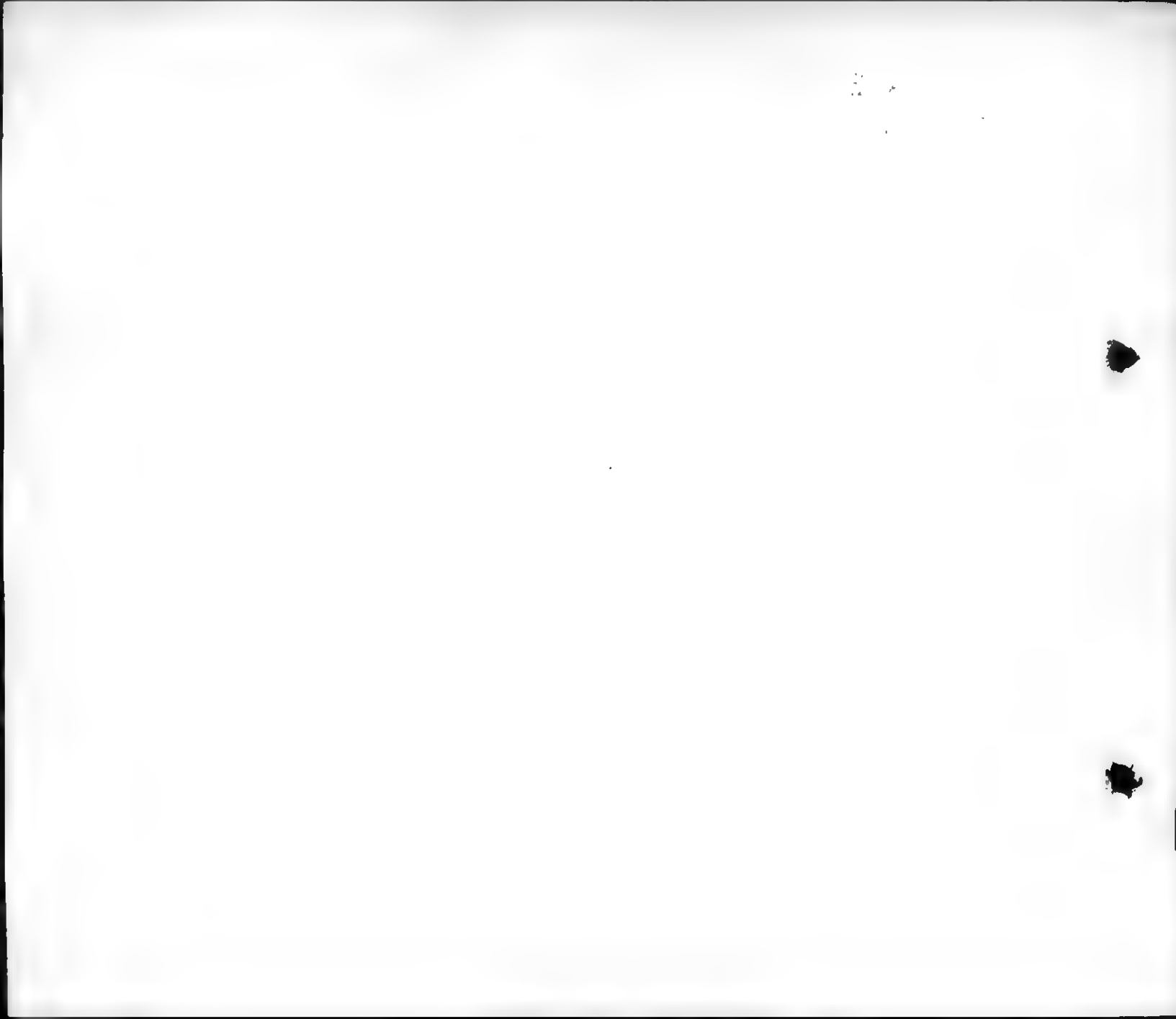
1. NAME OF DECEASED (Type or Print) <b>KECZMERSKI, JOHN F.</b>			2. DATE OF DEATH <b>1-21-56</b>		
3. PLACE OF DEATH: <b>Baltimore City, Maryland</b> <b>COUNTY</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>OVERLEA</b>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>7524 BELAIR RD.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>OVERLEA</b>		
c. Length of stay in Baltimore <b>48</b> Yrs. Mos. Days			d. STREET ADDRESS (If rural, give location) <b>7524 BELAIR RD.</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>FEB. 3, 1907</b>	9. AGE (In years last birthday) <b>48</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL LIQUOR</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>DANIEL KECZMERSKI</b>			14. MOTHER'S MAIDEN NAME <b>ANNA KOFFMAN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>(Yes, no or unknown)</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>DECEASED</b>		
			ADDRESS <b>SAME</b>		

18. <b>153X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>METASTATIC CARCINOMA</b> DUE TO <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>CARCINOMA OF SIGMOID</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>7 MONTHS</b> <b>1 YR.</b>
--	--	---

19. DATE OF OPERATION <b>10-1-55</b>		19A. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>EXPLORATION</b>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that (I) (this hospital) attended the deceased from **9-20** 19**55** to **JANUARY 21** 19**56**, that (I) (we) last saw the deceased alive on **JANUARY 21** 19**56**, and that death occurred at **5:15 P.M.** from the causes and on the date stated above.

23A. SIGNATURE <b>Paul G. Harold</b>		23B. ADDRESS <b>10 W. Madison St.</b>	23C. DATE SIGNED <b>January 22, 1956</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>JAN 25 56</b>	24C. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEMORIAL PARK</b>	24D. LOCATION (City, town, or county) (State) <b>TAYLOR AVE MD</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>1/23/56</b>	REGISTRAR'S SIGNATURE <b>H. W. Hedrick</b>	25. FUNERAL DIRECTOR <b>Label BND 7110 BELAIR RD</b>	





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

VS A15C 1 55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3 3

## CERTIFICATE OF DEATH

00290

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>BALTO.</u> <u>701 Nuxway St</u> CITY OR TOWN <u>RUXTON</u> <u>(4)</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SORENSEN NURSING HOME.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>---</u> CITY OR TOWN <u>BALTO. 13</u> STREET ADDRESS <u>1725 DARLEY AVE.</u>			
3. NAME OF DECEASED (Type or Print) <u>LEONA</u> <u>LOVE</u> <u>KEISTER</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>26</u> (Year) <u>1956</u>			
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10 JUNE 1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u>		IF UNDER 24 HRS Hours <u>4</u> Min <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALONZO BUTCHER</u>				14. MOTHER'S MAIDEN NAME <u>LYDIA</u> <u>(?)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>ROBT. W. KEISTER</u> <u>3405 SOLLERS POINT RD.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>101</u> IMMEDIATE CAUSE (A) <u>Carcinoma of the esophagus metastatic</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of the liver metastatic to esophagus</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>2005 upper right lobe of lung metastatic</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Anesthetic overdose</u>							
19a. DATE OF OPERATION <u>NO</u>		19b. MAJOR FINDINGS OF OPERATION <u>Right upper lobe of lung in situ metastatic</u>					20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>110</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>110</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) <u>no injury</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>no injury</u>			
22. I hereby certify that I attended the deceased from <u>Tell, Ill.</u> , 19 <u>56</u> , to <u>Tell, Ill.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-20-56</u> , and that death occurred at <u>5:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James Graham Marston</u>				ADDRESS (Street, city, town, state) <u>M.D. 516 Cathedral Street</u>		DATE SIGNED <u>I-27-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-30-56</u>		NAME OF CEMETERY OR CREMATORY <u>MIDCOWRIDGE</u>		LOCATION (City, town, or county) (State) <u>DEKSEY, IND</u>	
24. REC'D BY REGISTRAR DATE <u>1-30-56</u>		REGISTRAR'S SIGNATURE <u>Melvin Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Bruce Brudley of Burial, Ind.</u>		ADDRESS	

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34

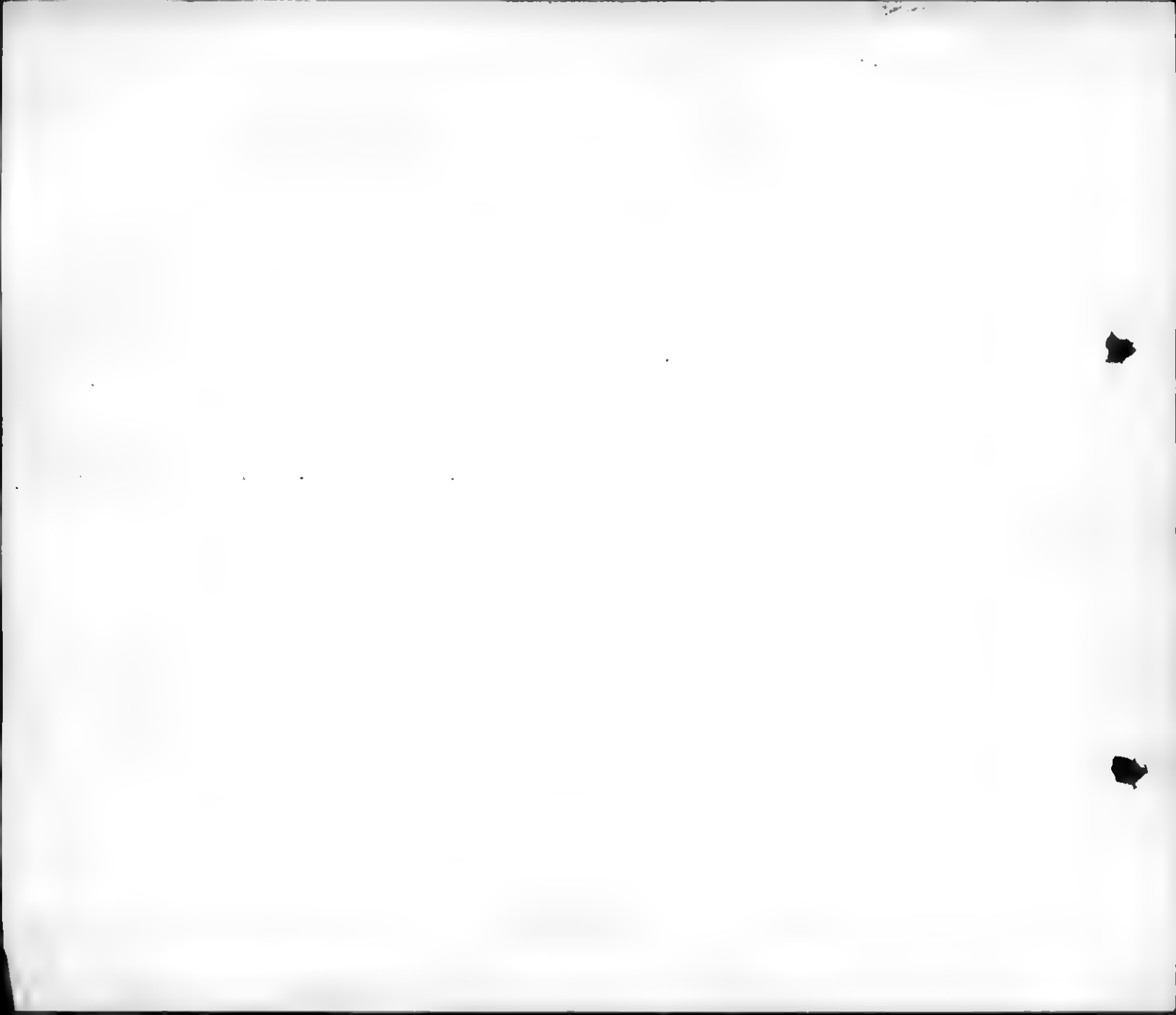
CERTIFICATE OF DEATH

Reg. Dist. No. ....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u>	LENGTH OF STAY (In this place) <u>22 Days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>3801 Fernhill Avenue</u>	
3. NAME OF DECEASED: (Type or Print) <u>ANTON P. KOPETZA</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>January 31, 19 56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>December 25, 1898</u>
9. AGE last birthday: <u>57</u> yrs.		10. MONTHS: <u>57</u>	11. DAYS: <u>57</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Peter Kopetza</u>	
14. MOTHER'S MAIDEN NAME: <u>Helen MN: Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>WW I</u>	
16. SOCIAL SECURITY NO. <u>219-10-8936</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>ADVANCED FIBROCALCAREOUS TUBERCULOSIS, LUNGS</u>			
ANTECEDENT CAUSE (B) <u>UNKNOWN</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 9, 1956</u> , to <u>Jan. 31, 1956</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>DONALD D. MARK, M.D.</u>		DATE SIGNED <u>2/2/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore, National</u>	
DATE THEREOF <u>2/3/56</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-3-56</u>		24. FUNERAL DIRECTOR <u>Hol Levinson &amp; Bros., 1126 W. North Ave. Md.</u>	

MARGIN RESERVE FOR BINDING



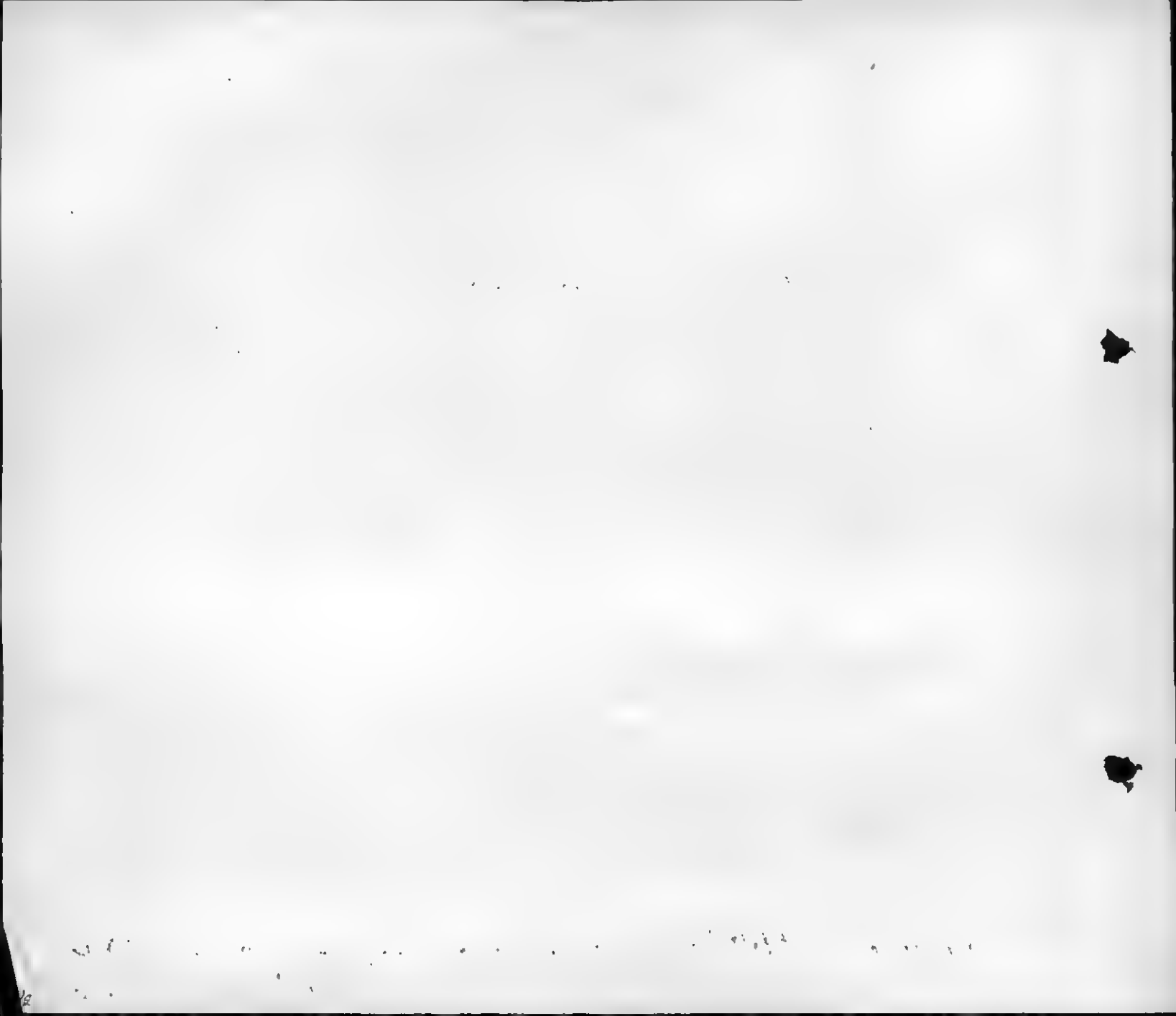
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 100291

## CERTIFICATE OF DEATH

Reg. Dist. No. 2,2

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MOUNT WILSON</u> LENGTH OF STAY (in this place) <u>141 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MOUNT WILSON STATE HOSPITAL</u>		STATE <u>MARYLAND</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE 24</u> STREET ADDRESS (If rural give location) <u>3609 FOSTER AVENUE</u> ✓	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>LAWRENCE</u> (Middle) (Last) <u>KWIATKOWSKI</u> (Type or Print)		(Month) (Day) (Year) <u>1 - 12 - 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>MALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>8 - 11 - 05</u>
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY?	
<u>50</u> yrs.		<u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>JAMES KWIATKOWSKI</u>		<u>ELIZABETH TOPELSKA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>NO</u>		<u>212-07-7427</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>HELEN HARNE SISTER 3609 FOSTER AVE BALTIMORE 24 MD</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>CARCINOMA OF LUNG</u> ANTECEDENT CAUSE (B) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8 24</u> , 1955, to <u>1 - 12</u> , 1956, that I last saw the deceased alive on <u>1 - 11</u> , 1956, and that death occurred at <u>2 50AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>William Newman</u>		ADDRESS <u>M.D. MOUNT WILSON MARYLAND</u>	
DATE SIGNED <u>1-14/56</u>		DATE SIGNED <u>1-12-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
<u>BURIAL</u>		<u>M.J. Sadowski &amp; Son, 1808 Eastern A</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/12/56</u>		REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	



306

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)TOWN Rural: TowsonLENGTH OF STAY  
(in this place)11 mo 20 dyHOSPITAL OR  
INSTITUTION ORSTREET ADDRESS Eudowood Sanatorium  
Towson 4, Maryland

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR  
TOWN BaltimoreSTREET  
ADDRESS

(If rural give location)

445 N. Ellwood Ave.3. NAME OF  
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

William B. Lambie4. DATE  
OF  
DEATH:

(Month)

(Day)

(Year)

Jan 27 19 56

## 5. SEX:

M6. COLOR OR  
RACE:W7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify):married

## 8. DATE OF BIRTH:

July 30 / 1884

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

71 yrs. Months: Days: Hours: Min.10a. USUAL OCCUPATION Give kind of  
work done during most of working life,  
even if retired:Registered letter10b. KIND OF BUSINESS OR  
INDUSTRY:A. & P. Co

## 11. BIRTHPLACE (State or foreign country):

W. S. A.12. CITIZEN OF WHAT  
COUNTRY?W. S. A.

## 13. FATHER'S NAME:

John D. Lambie

## 14. MOTHER'S MAIDEN NAME:

Emma Rogge15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.)no

## 16. SOCIAL SECURITY No.:

no

## 17. INFORMANT &amp; ADDRESS:

216-031-588Mr. William K. Lambie - 445 N. Ellwood Ave.

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002 X

Immediate cause

(a) ...

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.

(b)

DUE TO

(c)

Pulmonary TuberculosisInterval Between  
Onset And Death2 yr.

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.none

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Not While  
Work ☐ At Work ☐

## HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 7th, 1954, to Jan 27, 1956, that I last saw the deceasedalive on 25 Jan 1956, and that death occurred at 8:15 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

DATE SIGNED

William B. Lambie M.D. Eudowood Sanatorium - Towson 4, Md.23. BURIAL, CREMATION,  
REMOVAL (Specify)Burial

## DATE THEREOF

1/30/56

## NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem.

## LOCATION (City, town, or county)

Balto., Md.

## (State)

DATE REC'D BY LOCAL  
REGISTRARMay 28 1956

## REGISTRAR'S SIGNATURE

R. W.

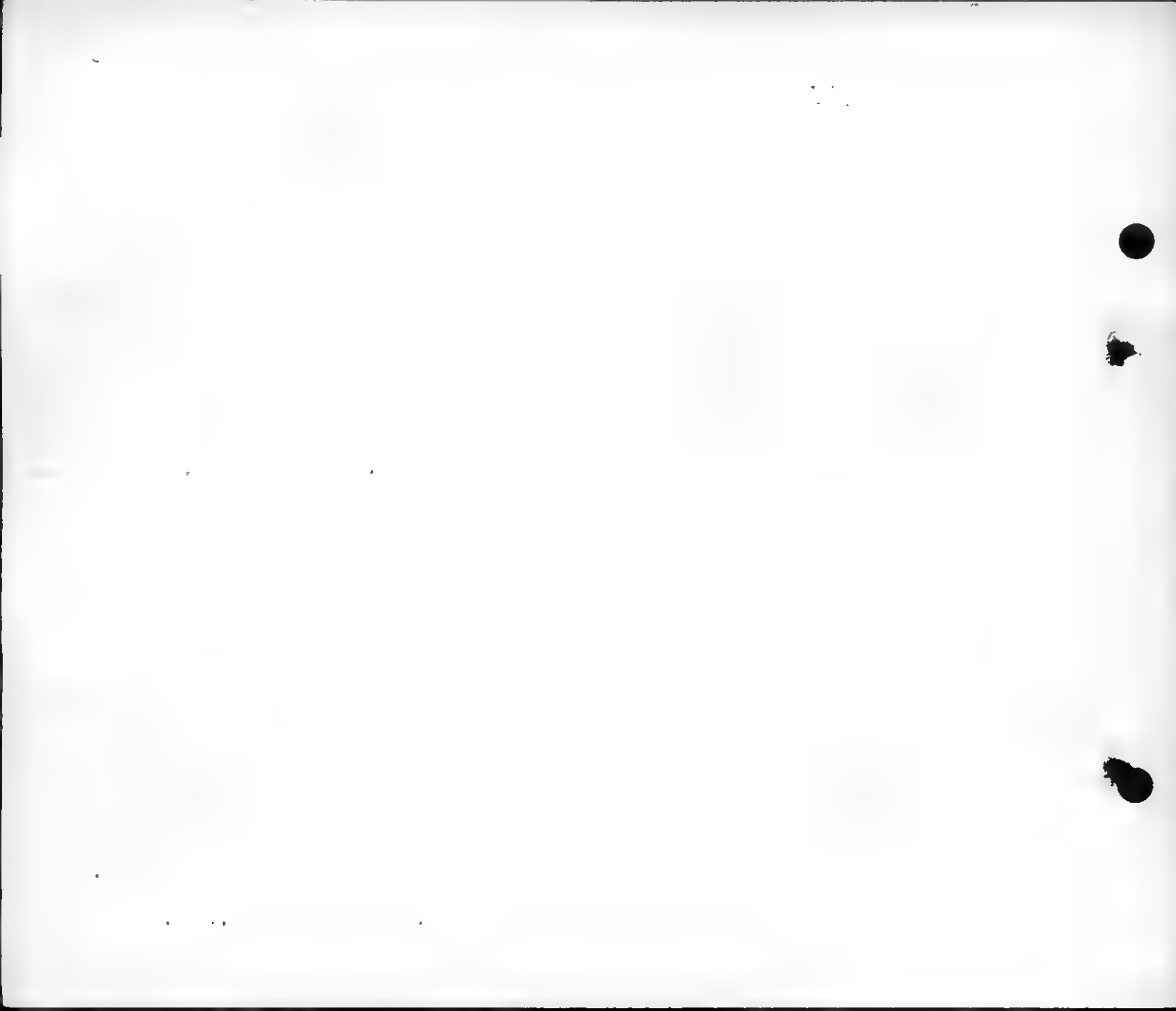
## 24. FUNERAL DIRECTOR

John J. Dickerson

## ADDRESS

Balto 17

MARGIN RESERVED FOR BINDING





1

307  
CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Parkville</b>				TOWN <b>Parkville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>9003 Harford Road</b>				STREET ADDRESS (If rural give location) <b>9003 Harford Road</b>			
3. NAME OF DECEASED (Type or Print) <b>Mrs. Anna Lane</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>January 30th 19 56</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	8. DATE OF BIRTH <b>July 25, 1895</b>	9. AGE last birthday <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mr. Frank Simacek</b>				14. MOTHER'S MAIDEN NAME <b>Sophia</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mr. Lester Lane, 9003 Harford Road</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
IMMEDIATE CAUSE (A) <b>Cachexia and debilitation</b>				2 yrs.			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Dehydration &amp; anemia</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>Cirrhotic liver</b>				1 yr.			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Arteriosclerosis</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTINUING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Feb 19 55</b> to <b>Jan 30 56</b> , that I last saw the deceased alive on <b>Jan 28 56</b> , and that death occurred at <b>3:4</b> M. from the causes and on the date stated above.							
SIGNATURE <b>Frank A. Karickhoff</b> M.D.				DATE SIGNED <b>1/30/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb. 2, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <b>Dr. A. M. Bacon</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Harford Road #14</b>	
DATE <b>Jan. 31, 1956</b>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

RECEIVED

FEB 1 1950

FEB 10 1950

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

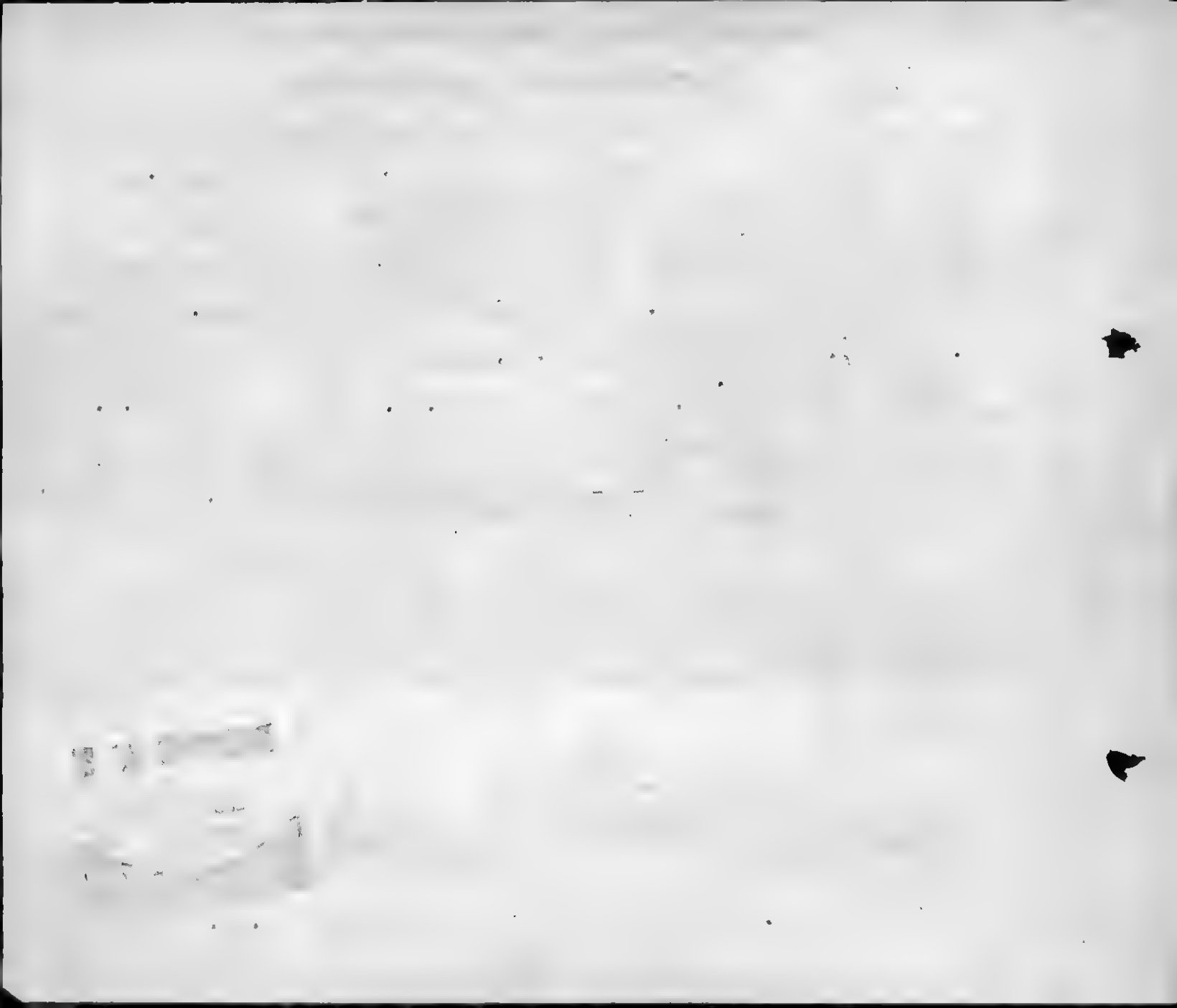
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206

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Md.</u>		COUNTY <u>Balto.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Arbutus</u>		<u>15 yrs</u>		TOWN <u>Arbutus</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1213 Maiden Choice Lane</u>				STREET ADDRESS (If rural give location) <u>1213 Maiden Choice Lane</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles</u> (Middle) <u>J.</u> (Last) <u>Langhirt</u>				(Month) <u>Jan.</u> (Day) <u>30</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M.</u>	<u>W.</u>	<u>Married</u>	<u>Nov. 16, 1899</u>	<u>56</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Supervisor</u>		<u>Int. Revenue</u>		<u>Balto. Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Sabastian Langhirt</u>				<u>Rose</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>212-07-0863</u>		<u>Miss Grace Langhirt, 1213 Maiden Choice Lane.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hemorrhage G.I. tract</u>						<u>15 Days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cancer of Stomach</u>						<u>3 month</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Apical RT Tuberculosis</u>						<u>unknown</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
		<u>M.</u>					
22. I hereby certify that I attended the deceased from <u>Jan 19</u> to <u>Jan 30, 1956</u> , that I last saw the deceased alive on <u>1/26</u> , 19 <u>56</u> , and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Cliff Davis</u>				ADDRESS (Street, city, town, state) <u>4605 Edmondson Ave</u>		DATE SIGNED <u>2/1/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 2/56</u>		<u>Loudon Park</u>		<u>Balto. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
				<u>Harry H. Witzke</u>		<u>4101 Edmondson Ave</u>	
DATE							



308

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>	LENGTH OF STAY (in this place) <u>2yr5mos26days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>1910 Park Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>John B. Larsen</u>		<u>January 6, 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>3-12-1889</u>
9. AGE last birthday <u>66</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Coppersmith</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>August A. Larsen</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Harble</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Lobar pneumonia</u>			<u>6 days</u>
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Suppurative parotitis</u>			<u>2 days</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-11-1953</u> to <u>1-6-1956</u> , that I last saw the deceased alive on <u>1-6-56</u> , 19 <u>56</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>S. L. Wachter</u>		DATE SIGNED <u>1-6-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 10, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/9/56</u>		24. FUNERAL DIRECTOR ADDRESS <u>Lilly &amp; Zeiler Inc., 403 S. Wolfe St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

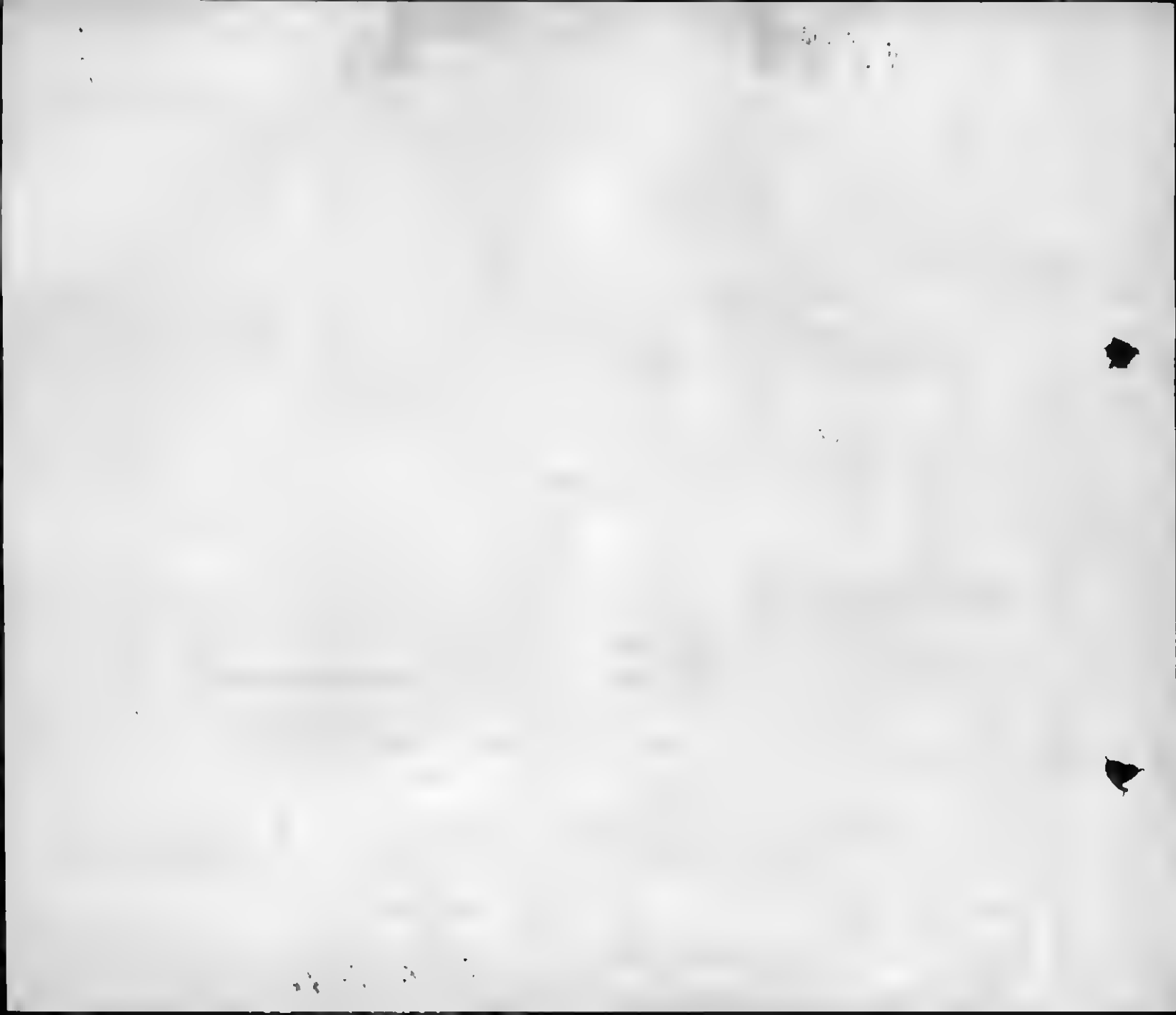
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309

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ruxton</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	3461
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorrenson Nursing Home 7912 Ruxway Road</u>		STREET ADDRESS (If rural give location) <u>Broadview Apartments</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>FLORENCE MAY LAYMAN</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 12, 19 56</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>May 16, 1874</u>
9. AGE last birthday: <u>81</u> yrs.		10. UNDER 1 YEAR: Months Days	11. UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>School Teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Education</u>	
11. BIRTHPLACE (State or foreign country): <u>Chesterville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Henry Clay Layman</u>		14. MOTHER'S MAIDEN NAME: <u>Susanna Brock Ford</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCE? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT & ADDRESS: <u>Allan H. Layman, 1535 East 35th St.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) DUE TO <u>Hemiplegic Cerebral</u>			<u>6-10-55</u>
ANTECEDENT CAUSE (B) DUE TO <u>Unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Arteriosclerosis</u>			<u>None</u>
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 12, 1956</u> to <u>Jan. 12, 1956</u> , that I last saw the deceased alive on <u>Jan. 12, 1956</u> , and that death occurred at <u>12:00 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Ernest C. Brown</u>		DATE SIGNED <u>M.D. 1101 11. Carroll St Jan 15/1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>	DATE THEREOF <u>1/14/56</u>	NAME OF CEMETERY OR CREMATORY <u>Stillpond Cemetery</u>	LOCATION (City, town, or county) (State) <u>Still Pond, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>1/10/56</u>	REGISTRAR'S SIGNATURE <u>J. H. Hedrick</u>	24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>	ADDRESS <u>1217 St. Paul St.</u>





210

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

COUNTY

BALTO.

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

CATONSVILLE

LENGTH OF STAY  
(in this place)

7 yrs

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Spring Grove Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md.

COUNTY

Balto.

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR

TOWN

BALTO.

STREET  
ADDRESS

(If rural give location)

Gwynn Oak Ave. 61 Liberty Hts.

3. NAME OF  
DECEASED  
(Type or Print)

(First)

(Middle)

(Last)

JOHN B. LECKNER

## 4. DATE (Month) (Day) (Year)

1-3-56 19

## 5. SEX.

M

## 6. COLOR OR RACE:

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify):

M

## 8. DATE OF BIRTH:

2-20-1888

## 9. AGE last birthday

67 yrs.

## IF UNDER 1 YEAR

## IF UNDER 24 MRS.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):

Householder

10B. KIND OF BUSINESS  
OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Lewis Leckner

## 14. MOTHER'S MAIDEN NAME:

Catherine Ward

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

No

## 16. SOCIAL SECURITY NO.

Unknown

## 17. INFORMANT &amp; ADDRESS:

Brooks Spring Grove Hosp.

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

230X

## IMMEDIATE CAUSE

## ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(A) DUE TO

Cerebral Thrombosis

(B) DUE TO

Cerebral Arteriosclerosis

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH

Arteriosclerotic Cardiovascular Disease

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR? (County) (State)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While ☐ Not while ☐  
at work at work

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-19-53 to 1-3-1956 that I last saw the deceased

alive on 1-3-1956 and that death occurred at 6:45 AM, from the causes and on the date stated above.

SIGNATURE

Stella Wachter

ADDRESS

Grove State Hosp.

DATE SIGNED

M.D. Catonsville 25 Md. 1-3-56

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

## DATE THEREOF

1/6/56

## NAME OF CEMETERY OR CREMATORY

London Park Cemetery Baltimore, Md.

## LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL  
REGISTRAR

Jan 4, 56

## REGISTRAR'S SIGNATURE

A. N. Heckrich Jr.

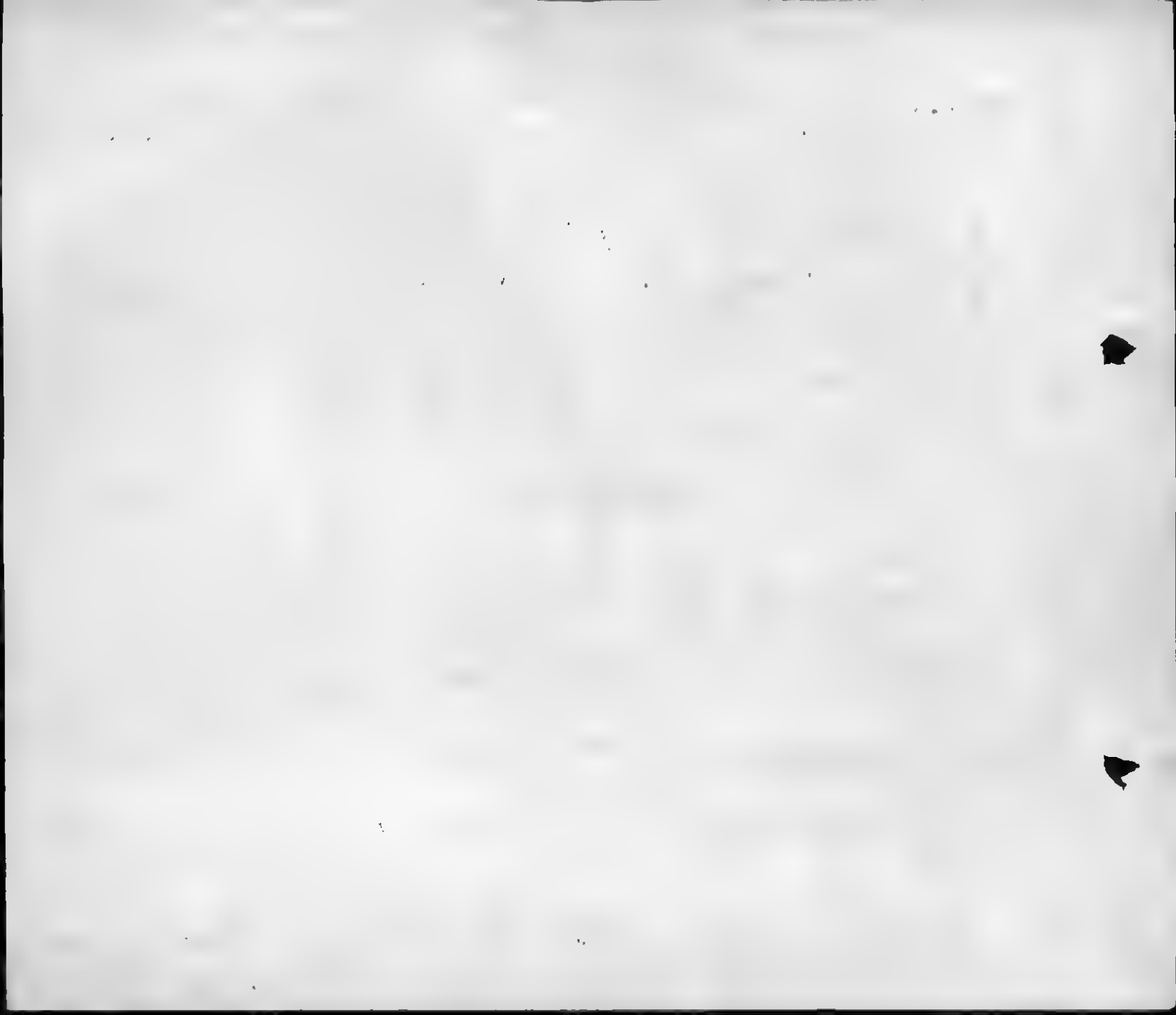
## 24. FUNERAL DIRECTOR

Wm. Cook, Inc. 1217 St Paul St

## ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



311

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FORT HOWARD,</u>	LENGTH OF STAY (in this place) <u>7 DAYS</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE #2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>608 STERLING STREET</u>	
3. NAME OF DECEASED: (Type or Print) <u>WILLIAM N. LeCOURT</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>JANUARY 13 19 56</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>COLORED</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>OCTOBER 16, 1888</u>
9. AGE last birthday: <u>67</u> Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>PORTER</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>PORTER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>HOSPITAL</u>	
11. BIRTHPLACE (State or foreign country): <u>PHILADELPHIA, PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>GEORGE LeCOURT</u>		14. MOTHER'S MAIDEN NAME: <u>BELLA YOUNG</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES WW I</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT & ADDRESS: <u>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>CARCINOMATOSIS</u>		<u>9 Months</u>	
ANTECEDENT CAUSE (B) <u>ADENOCARCINOMA OF RECTUM</u>		<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION.		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 6, 1956, to Jan. 13, 1956, that I pronounced the deceased dead, and that death occurred at 10:45 AM from the causes and on the date stated above.			
SIGNATURE <u>Irving Freeman</u>		ADDRESS <u>VAH Ft. Howard, Md</u>	
DATE SIGNED <u>1/13/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE WHEREOF <u>1-17-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) <u>Balto, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>January 14 1956</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>	
24. FUNERAL DIRECTOR <u>Joseph G. Locks, Jr</u>		ADDRESS <u>1304 N. Central AVE Balto. Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

00299

Item 18 Film GL91 1-23-56

312

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 3

1. PLACE OF DEATH: COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> (22)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location) <u>6504 Colgate Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Antonio</u> (Middle) <u>MARTINEZ</u> (Last) <u>Lerio</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 11, 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-13-1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pin Mill Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFR.</u>	9. AGE (last birthday) (If under 1 year) (If under 24 hrs.) <u>52</u> yrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Spain</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u> ✓	
13. FATHER'S NAME <u>Martius Lerio</u>		14. MOTHER'S MAIDEN NAME <u>Mary?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u> <u>No</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Records Spring Grove State Hospital</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Leading Congestive heart failure</u>		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Acute coronary thrombosis</u>		
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE Dr. M. Kieffer, M.D. (Degree or title) ADDRESS 1010 Leeds Avenue DATE SIGNED 1-12-56  
State Balto Arbutus, Maryland

23. BURIAL, CREMATION, DATE THEREOF, NAME OF CEMETERY OR CREMATORY, LOCATION (City, town, or county), (State)  
BURIAL 1/14/56 MEADOWRIDGE DORSEY, Md.

DATE REC'D BY LOCAL REG. 1-14-56 REGISTRAR'S SIGNATURE W. E. Harry 24. FUNERAL DIRECTOR ADDRESS Walter Burke Bradley, DUNDACK, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 17 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00390

313

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>2yr. 5mo. 18dys</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE STATE HOS ITAL</u>				STREET ADDRESS (If rural give location) <u>4217 Woodmore Ave. -</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Hyman</u> <u>Levin</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1-10-56</u> <u>19</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Jan; 1, 1871</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROCCER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country): <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>	
13. FATHER'S NAME: <u>Joseph Levin</u>				14. MOTHER'S MAIDEN NAME: <u>Ida ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS: <u>Records of Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>						years	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) <u>Generalized arteriosclerosis</u>							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>debility and senility</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-22</u> , <u>1953</u> , to <u>1-10</u> , <u>1956</u> that I last saw the deceased alive on <u>1-10</u> , <u>1956</u> , and that death occurred at <u>1:00p</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Stella Wachler</u>		ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>		DATE SIGNED <u>1-10-56</u>		(State) <u>M.D. Catonsville 28, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 11 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Bnai Israel</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/11/56</u>		REGISTRAR'S SIGNATURE <u>G.W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Sol. Harrison &amp; Son</u>		ADDRESS <u>1124-26 W. North Ave</u>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 100001  
314  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
CITY (If outside corporate limits, write RURAL and give nearest town)  
TOWN Owings Mills LENGTH OF STAY (in this place) 1 1/2 yrs.  
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rosewood State Tr. School

2. USUAL RESIDENCE (HOME) OF DECEASED.

STATE Maryland COUNTY Frederick  
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick  
STREET ADDRESS (If rural give location) 211 East 5th Street

3. NAME OF DECEASED:

(First) (Middle) (Last)  
LeRoy Loker Lipps

4. DATE (Month) (Day) (Year)  
OF DEATH: 1 18 19 56

5. SEX.

6. COLOR OR RACE:  
male white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single

8. DATE OF BIRTH 4/18/03

9. AGE last birthday: 52 yrs. IF UNDER 1 YEAR: Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Thomas Sylvester Lipps

14. MOTHER'S MAIDEN NAME:

Mamie Mariah Loker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT & ADDRESS.

Rosewood Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A) Acute Broncho-Pneumonia

ANTECEDENT CAUSE (B):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

1-2 days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Mental Deficiency

since birth

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID (City or town) INJURY OCCUR?

(County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/16, 19 56 to 1/18, 1956, that I last saw the deceased alive on 1/18, 19 56, and that death occurred at 8:35a M., from the causes and on the date stated above.

SIGNATURE

Harry B. Butler M.D.

ADDRESS

Owings Mills Md Jan 5 DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) DATE THEREOF

Burial

21 Jan 1956

NAME OF CEMETERY OR CREMATORY

Mount Olivet Cemetery

LOCATION (City, town or county) (State)

Frederick, Maryland

DATE REC'D BY LOCAL REGISTRAR

Jan. 20, 1956

REGISTRAR'S SIGNATURE

Mary Eline

24. FUNERAL DIRECTOR

M. R. Etchison & Son, Frederick, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1900

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 2, Film G192 2-1-56 et

## 1. PLACE OF DEATH:

COUNTY

Balto

MARYLAND

CITY (If outside corporate limits, write RURAL LENGTH OF STREET OR and give nearest town) (in this place)  
Lutherville 2 1/2 yrs.HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

College Manor.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

Balto

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN GarrisonSTREET  
ADDRESS

(If rural give location)

Garrison Forest School

3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

(Last)

Mary Moncrieffe Livingston.

4. DATE  
OF  
DEATH:

(Month)

(Day)

(Year)

Jan. 26 1956

## 5. SEX:

F

6. COLOR OR  
RACE:

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify):

Single

## 8. DATE OF BIRTH:

Feb 9, 1869

## 9. AGE last birthday:

86

Months Days

Hours Min.

10a. USUAL OCCUPATION. Give kind of  
work done during most of working life,  
even if retired):

Teacher

10b. KIND OF BUSINESS OR  
INDUSTRY:

School

## 11. BIRTHPLACE (State or foreign country):

Ohio

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Moncrieffe Livingston.

## 14. MOTHER'S MAIDEN NAME:

Esther Harvey Dibblee.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

No

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) ...

Cerebral hemorrhage

DUE TO

## Antecedent causes (s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.

(b) ...

Blow on head

DUE TO

(c)

arterio-sclerosis

Interval Between  
Onset And Death

7 days

7 days

25 yrs.

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐

## 21. ACCIDENT

(Specify)

Home

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)

INJURY

Home

CITY OR TOWN

Lutherville

(COUNTY)

Balto.

(STATE)

Md.

TIME (Month) (Day) (Year) (Hour)  
OF INJURY 1/26/56 7:30 m.

## INJURY OCCURRED

While at Work

Not While at Work

## HOW DID INJURY OCCUR?

Fell &amp; struck head.

22. I hereby certify that I attended the deceased from Feb 9, 1932 to Jan 26, 1956 that I last saw the deceased

alive on 1/26, 1956, and that death occurred at 2 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Palmer F.C. Williams

M.D. Pikesville, Md.

1/26/56

23. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

DATE THEREOF

Jan 28/56

NAME OF CEMETERY OR CREMATORY

St Thomas

LOCATION (City, town, county, (State)

Garrison Forest

DATE REC'D BY LOCAL  
REGISTRAR

Jan. 27, 1956

REGISTRAR'S SIGNATURE

Mabel C. Gray

24. FUNERAL DIRECTOR

H.H. Jenkins &amp; Sons Co 4905 York Rd

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. A.

1911

RECEIVED

316

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00303

## CERTIFICATE OF DEATH

Reg. Dist. No.

Item 9, Baltimore 2-3-56 et

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) Towson  
 TOWN Rural: Towson LENGTH OF STAY (in this place)  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Eudowood Sanatorium Towson 4, Maryland

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore  
 TOWN Baltimore COUNTY 7  
 STREET ADDRESS (If rural give location) 3401 Ripple Rd.

## 3. NAME OF DECEASED:

(First) Philip (Middle) M. (Last) Lockwood  
 (Type or Print)

4. DATE OF DEATH: (Month) Jan (Day) 27 (Year) 1956

## 5. SEX:

M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: June 1, 1918

9. AGE last birthday: 38 yrs. Months 7 Days 7 Hours 7 Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

10b. KIND OF BUSINESS OR INDUSTRY: Salesman

11. BIRTHPLACE (State or foreign country): Baltimore City

12. CITIZEN OF WHAT COUNTRY? US.

## 13. FATHER'S NAME:

William Lockwood

## 14. MOTHER'S MAIDEN NAME:

Margaret Bagley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no

16. SOCIAL SECURITY No.: 212-03-7496

17. INFORMANT & ADDRESS: Personal History Hospital Records, Eudowood Sanatorium.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Pulmonary Tuberculosis.

Interval Between Onset And Death

24+3

DUE TO

Antecedent causes (s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/19, 1956, to 1/27, 1956, that I last saw the deceased

alive on 1/27, 1956, and that death occurred at 11:05 PM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William B. Kues M.D. Eudowood Sanatorium - Towson 4, Maryland

## 23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BURIAL DATE REC'D BY LOCAL REGISTRAR

1/30/56 REGISTRAR'S SIGNATURE

WOODLAWN CEMETERY

WOODLAWN-MARYLAND

## 24. FUNERAL DIRECTOR

HENRY SANDER & SONS INC.

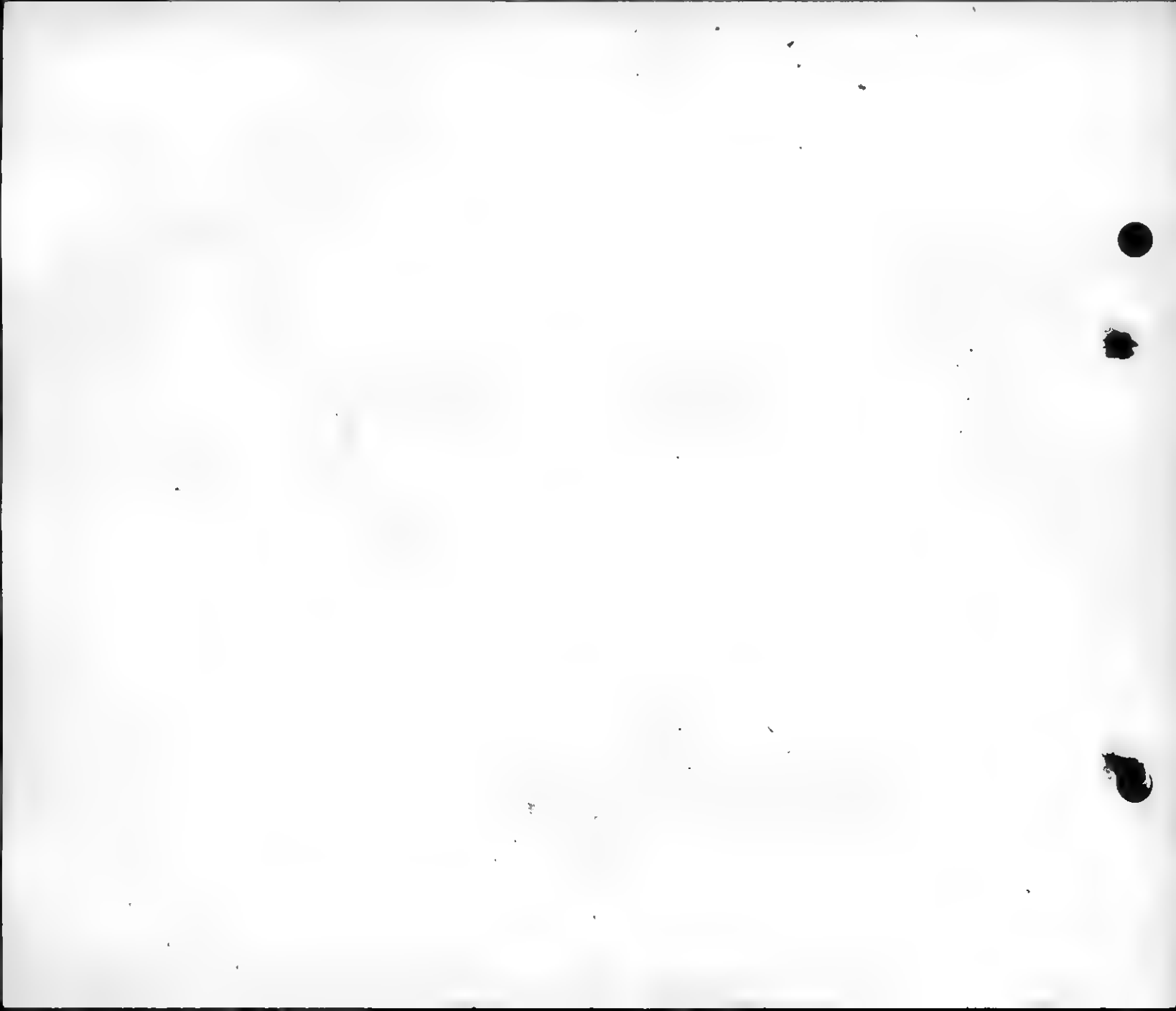
BALTIMORE-MARYLAND

Henry F. Sander

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

317

## CERTIFICATE OF DEATH

00304

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ruxton</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorensen Nursing Home</u> <u>7912 Ruxway</u>				STREET ADDRESS <u>1415 Linden Avenue</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Walter Bernard Logan</u>				4. DATE OF DEATH <u>January 2, 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Aug. 17, 1875</u>	
9. AGE last birthday <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Eugene Logan</u>				14. MOTHER'S MAIDEN NAME <u>Mary O'Neill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Walter G. Logan</u> <u>24 Morris La. Scarsdale N. Y.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>				year			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocarditis - chronic decompensating</u>				years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input checked="" type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> el work <input type="checkbox"/> Cal work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-31-55</u> to <u>1-2-56</u> , that I last saw the deceased alive on <u>1-2-56</u> and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James L. Saffell</u>		M.D.		ADDRESS (Street, city, town, state) <u>Keisterman Rd</u>		DATE SIGNED <u>1-3-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/5/56</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>JAN 3 1956</u>		REGISTRAR'S SIGNATURE <u>Mabel Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins and Sons Co.</u>		ADDRESS <u>4905 York Rd.</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

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103



## CERTIFICATE OF DEATH

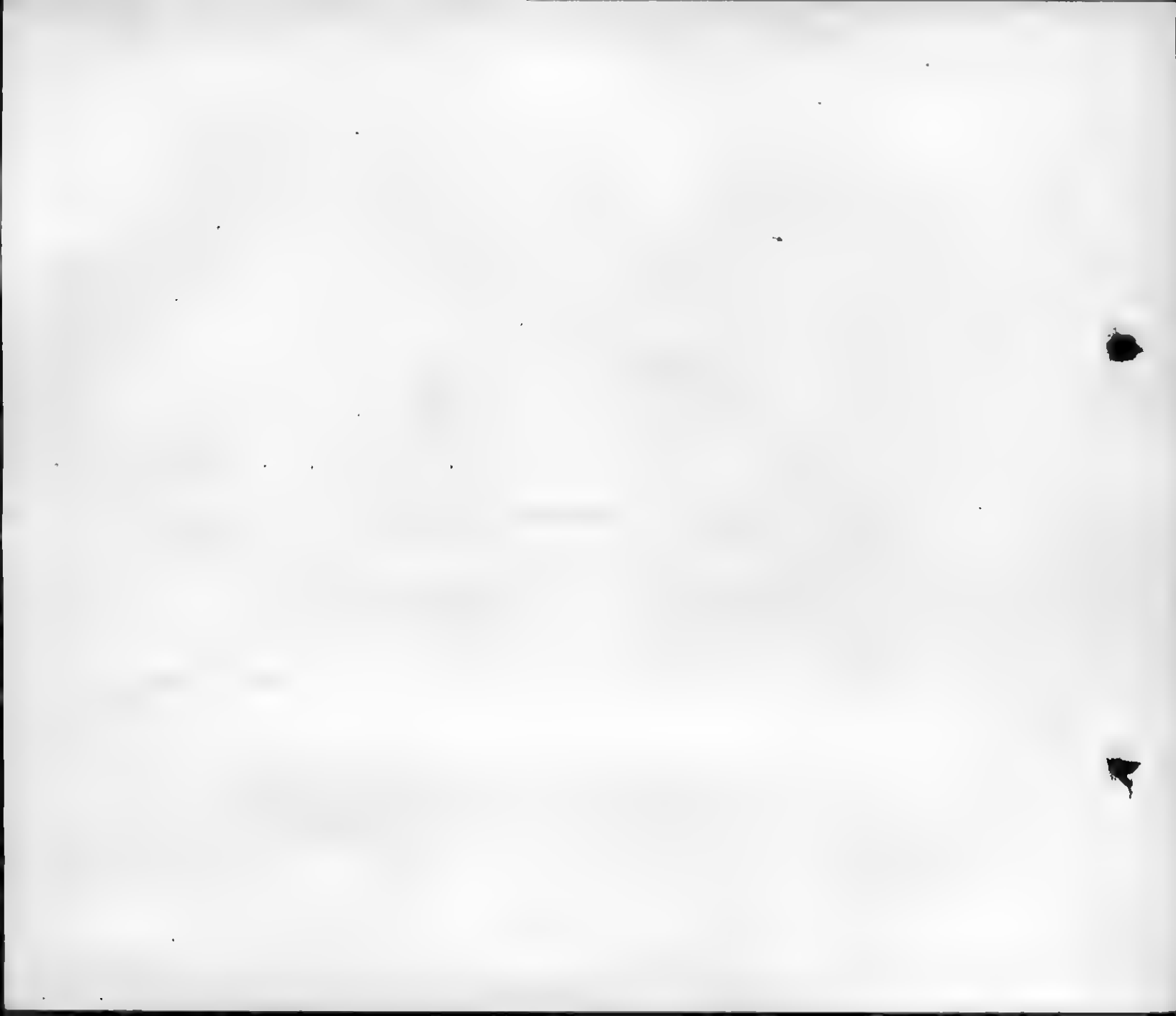
Reg. Dist. No.

318

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL, OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Hemwood Heights</b>			
TOWN <b>Hemwood Heights</b>				STREET ADDRESS (If rural give location) <b>20 Sheraton Rd.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>20 Sheraton Rd.</b>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<b>Lewis Cadwallader Loveland</b>				<b>Jan. 19 19 56</b>			
5. SEX.	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 MRS.	
<b>Male</b>	<b>White</b>	<b>Widowed</b>	<b>May 5, 1889</b>	<b>66</b> yrs	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Money counter</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>Race Trade</b>		11. BIRTHPLACE (State or foreign country): <b>Baltimore, Md.</b>	
13. FATHER'S NAME: <b>William Loveland</b>				14. MOTHER'S MAIDEN NAME: <b>Fannie B. Cadwallader</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>No</b> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>218-05-6397 A</b>		17. INFORMANT & ADDRESS: <b>Mrs. C. W. Rush, Sr. - 20 Sheraton Rd.</b>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)				DUE TO <b>Arteriosclerotic heart disease 2 yrs</b>			
ANTECEDENT CAUSE (B)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>5 Aug, 1948</b> to <b>19 Jan, 1956</b> , that I last saw the deceased alive on <b>21 Dec, 1956</b> , and that death occurred at <b>2 P. M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Paul H. Rouse</b>		M. D. <b>Ricksville 8 Md</b>		DATE SIGNED <b>19 Jan 56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1/23/1956</b>		NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>1/23/56</b>		REGISTRAR'S SIGNATURE <b>A. M. H. H. H.</b>		24. FUNERAL DIRECTOR <b>Ellsworth Armacost</b>		ADDRESS <b>2600 Liberty Hgts. Ave.</b>	

MARGIN RESERVED FOR BINNING



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 TOM

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

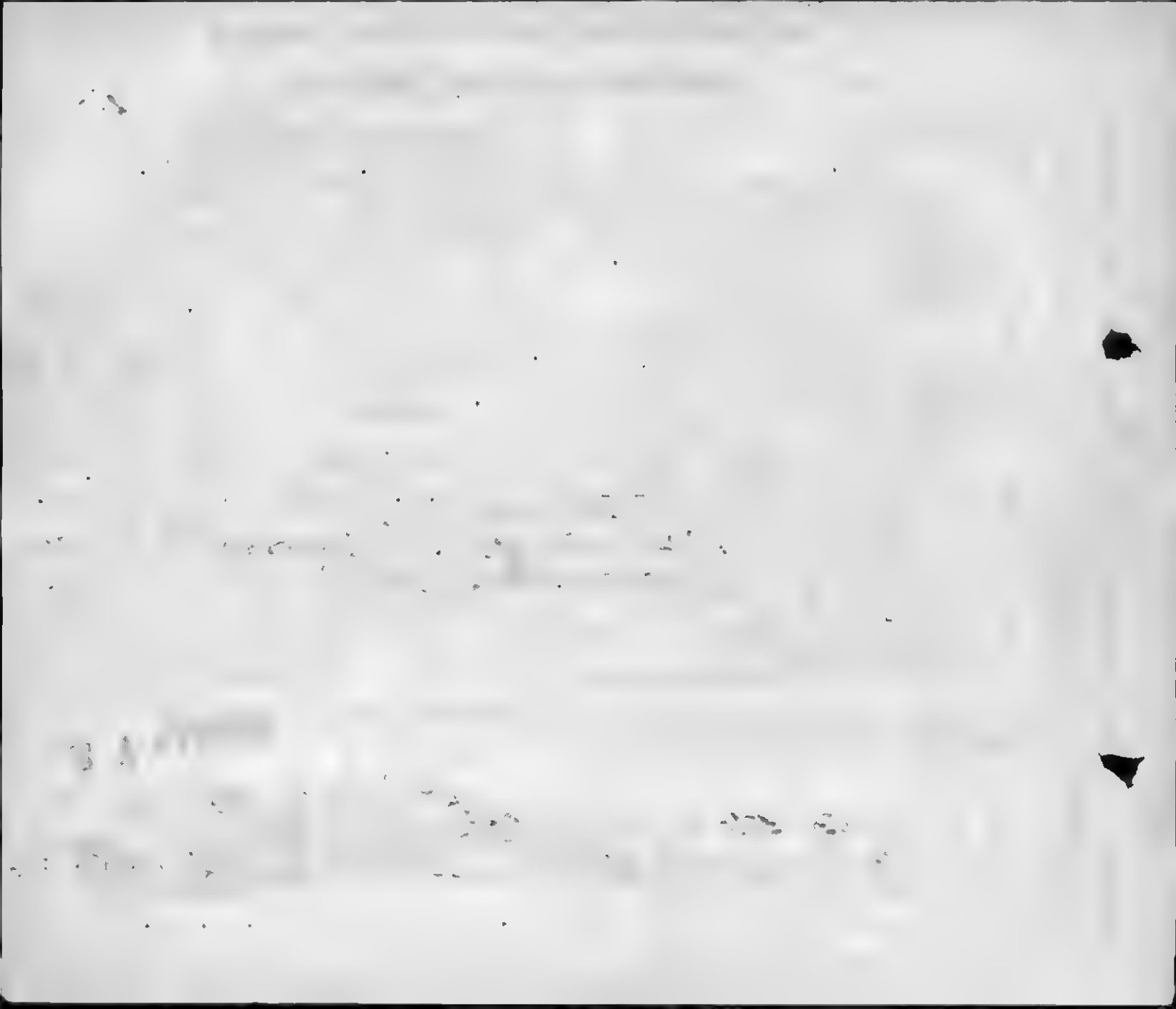
00306

319

## CERTIFICATE OF DEATH

Reg. Dist. No. <sup>38</sup>~~110~~

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>20 Chesapeake Ave.</u>				STREET ADDRESS (If rural give location) <u>20 Chesapeake Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>JOSHUA</u> (First) <u>LYNCH</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> Jan. <u>5</u> , 19 <u>56</u> (Month) (Day) (Year)			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov. 8, 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours M.n.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Court House</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William R. Lynch</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Grace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-03-0746</u>		17. INFORMANT & ADDRESS <u>Mrs. M. G. Lynch-20 W. Chesapeake Ave. Towson, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Influenza + Bronchitis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiac Insufficiency</u>				<u>5 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 3, 1956</u> to <u>Jan. 3, 1956</u> that I last saw the deceased alive on <u>Jan. 3, 1956</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter W. Hammett</u> M.D.				DATE SIGNED <u>Jan 5-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 6, 1956</u>		REGISTRAR'S SIGNATURE <u>Mabel Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner &amp; Sons - Balto</u>			





Dr. L. H. Owen

John Burleigh Jr

and John  
S. P.  
J. L. Palmer

321

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u>		LENGTH OF STAY (in this place) <u>65 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>REISTERSTOWN ROAD</u>				STREET ADDRESS (If rural give location) <u>REISTERSTOWN- ROAD</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>MINNIE AGNES MAHON</u>				<u>Jan - 13 - 1956</u>			
5. SEX: <u>FEMALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>Nov 23, 1896</u>	
9. AGE last birthday: <u>79</u> yrs.		10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>HOME</u>		11. BIRTHPLACE (State or foreign country): <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>JOEL REINECKER</u>		14. MOTHER'S MAIDEN NAME: <u>Carroll Horwille</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>	
16. SOCIAL SECURITY No.: <u>220</u>		17. INFORMANT'S ADDRESS: <u>Mrs. Frank Horner - Owings Mills</u>					

18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause		(a) <u>Coronary Thrombosis</u>	Interval Between Onset And Death <u>1 hr.</u>
Antecedent causes (s)		DUE TO (b) <u>Chronic myocarditis</u>	<u>3 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		DUE TO (c) <u>Myocardial infarction</u>	<u>5 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from <u>JAN. 12, 1950</u> , to <u>JAN. 13, 1956</u> , that I last saw the deceased alive on <u>JAN. 12, 1956</u> , and that death occurred at <u>5:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James A. Diller, Jr.</u>		DATE SIGNED <u>1/14/56</u>					
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>		<u>Woodlawn</u>		<u>Woodlawn, Maryland</u>		<u>Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 14, 1956</u>		REGISTRAR'S SIGNATURE <u>James A. Diller, Jr.</u>		24. FUNERAL DIRECTOR		ADDRESS <u>Frank H. Spurr - Pikesville Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WORMS V. B.

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322

## CERTIFICATE OF DEATH

Reg. Dist. No. 18

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Balto.</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Ruxton</b>		LENGTH OF STAY (In this place) <b>9 Wks.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Sorensen Nursing Home 7912 Ruxton Dr. Ruxton Md.</b>				STREET ADDRESS (If rural give location) <b>4231 Flowerton Rd</b>			
3. NAME OF DECEASED (First) (Middle) (Last) <b>Joseph J. Maloney</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 9 19 56</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>Jun. 8, 1883</b>	9. AGE last birthday <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bartender</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Maloney</b>				14. MOTHER'S MAIDEN NAME <b>Bridgit</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>(If Yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>220-03-6120</b>		17. INFORMANT & ADDRESS <b>Mrs Bartus E. Wigley, 4231 Flowerton</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
441X IMMEDIATE CAUSE (A) <b>Myocarditis chronic with infarct</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
ANTECEDENT CAUSE(S) DUE TO <b>Myocarditis hypertrophic</b>						<b>3 years</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>arteriosclerosis general</b>						<b>10 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <b>none</b>		19b. MAJOR FINDINGS OF OPERATION <b>no operation</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <b>no injury</b>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <b>no injury</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>no injury</b>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> <b>M. at work</b>		21f. HOW DID INJURY OCCUR? <b>no injury</b>			
22. I hereby certify that I attended the deceased from <b>Oct 27</b> , 19 <b>55</b> , to <b>Jan 9</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Jan 9</b> , 19 <b>56</b> , and that death occurred at <b>6:00</b> M., from the causes and on the date stated above.							
SIGNATURE <b>James Graham Martin</b>				ADDRESS (Street, city, town, state) <b>210 Cathedral Street, Baltimore, Md.</b>			
DATE <b>Jan 12/56</b>				DATE SIGNED <b>Jan 10, 1956</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Jan. 12/56</b>		NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24. REC'D BY REGISTRAR <b>1/13/56</b>		REGISTRAR'S SIGNATURE <b>Maude C. Gray</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Wigley</b>		ADDRESS <b>4101 EDMONDSON AVE</b>	

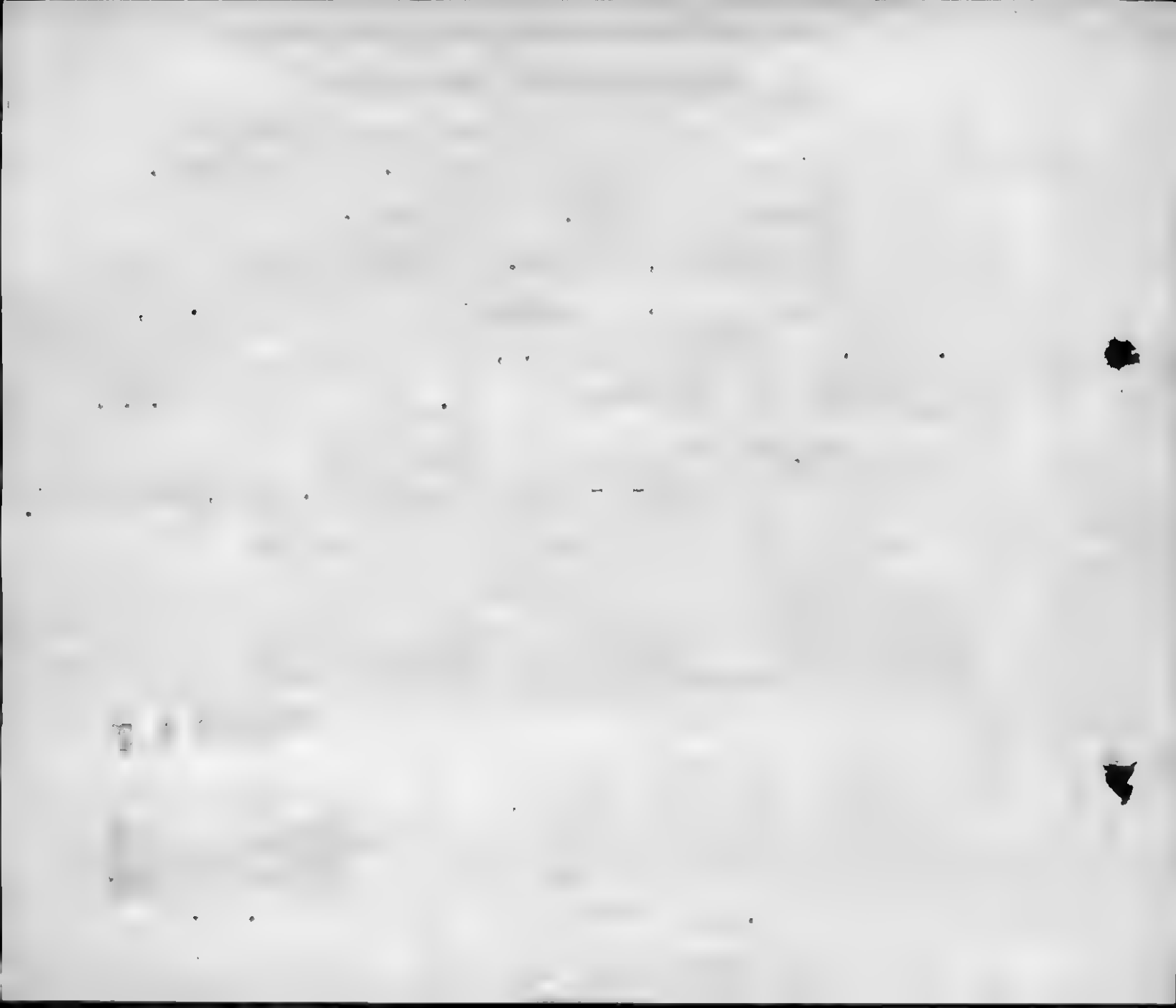
**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OF HOSPITAL** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

**TO ATTENDING PHYSICIAN OF HOSPITAL** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



323

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Annapolis	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN Catonsville		17 yrs.		TOWN Catonsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
1600 Idlewild Ave.							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Ethel Fisher Mason				Jan. 18, 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	W	Married	Aug. 20, 1887	68 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if railroad)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housekeeper		Home		W. Va.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Sanford F. Fisher				Florence Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		---		Mrs. P. W. Peters 1600 Idlewild			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				MYOCARDITIS CHRONIC.			
ANTECEDENT CAUSE(S) DUE TO				CEREBRAL HEMORRHAGE.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				ARTERIOSCLEROSIS.....			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				2-3 years			
				6 MONTHS			
				years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
0							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
		0					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
0							
22. I hereby certify that I attended the deceased from JULY, 26, 1954, to Jan., 18, 1956, that I last saw the deceased alive on JAN., 18, 1956, and that death occurred at 10:08 PM, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
M.D. Catonsville Md.				Jan., 20, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1-21-56		Lorraine Park		Woodlawn Md.	
24. RECEIVED BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Jan. 27, 1956		V. E. Harry		Foreign Funeral Home - Catonsville, Md.			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



# MARYLAND STATE DEPARTMENT OF HEALTH

00311

2411 N. Charles Street, Baltimore

324

## CERTIFICATE OF DEATH

Reg. Dist. No. 2

Item 8, File 193 2-27-56 et

1. PLACE OF DEATH COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>OR TOWN Catonsville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>61 Winters Lane</b>		STREET ADDRESS (If rural, give location) <b>61 Winters Lane</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>Louise</b>	(Middle) <b>Matthews</b>	(Last)
4. SEX <b>Female</b>	5. COLOR OR RACE <b>Colored</b>	6. DATE OF BIRTH <b>2-14-1914</b>	7. AGE last birthday <b>40</b> yrs.
8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	9. DATE OF DEATH <b>Jan. 11, 1956</b>	10. MONTH (Day) (Year)	11. IF under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>Jefferson Berbour</b>		14. MOTHER'S MAIDEN NAME <b>Alice Step</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <b>Mr. Raymond Matthews Winters La.</b>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <b>Myocardial infarct</b>	<b>Shows</b>
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last <b>Hypertensive Cardiac Disease</b>	<b>10-15 years</b>
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb**, 19**55**, to **Jan**, 19**56**, that I last saw the deceased alive on **11 Jan**, 19**56**, and that death occurred at **11 P.** m., from the causes and on the date stated above.

SIGNATURE: **C. R. Sanitem, M.D.** ADDRESS: **305A Winters Ave, Baltimore 28 Md.** DATE SIGNED: **11 Jan 56**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>1-15-56</b>	NAME OF CEMETERY OR CREMATORY <b>Western Star Cem.</b>	LOCATION (City, town, or county) (State) <b>Catonsville Md.</b>
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DATE REC'D BY LOCAL REG. **1/13/56** REGISTRAR'S SIGNATURE **W. H. Hedrick** FUNERAL DIRECTOR **W. H. Hedrick** ADDRESS **W. H. Hedrick**

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.



325

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO-</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>SPARKROWS POINT</u>		LENGTH OF STAY (In this place) <u>57</u>		CITY (If outside Corporate limits, write RURAL and give nearest town) <u>SPARKROWS POINT (19)</u>			
HOSPITAL OR INST. TUTION OR STREET ADDRESS <u>617 E ST.</u>				STREET ADDRESS (If rural give location) <u>617 E ST.</u>			
3. NAME OF DECEASED (Type or Print) <u>JOHN ANDREW M<sup>C</sup>FADDEN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1-20-1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JULY 29, 1869</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFR.</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm M<sup>C</sup>FADDEN</u>				14. MOTHER'S MAIDEN NAME <u>ISABELLA (?)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-10-0096</u>		17. INFORMANT & ADDRESS <u>MARY MCH. MCFADDEN - SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral atherosclerosis</u>						<u>15 to 20</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1956</u> to <u>Jan 20, 1956</u> , that I last saw the deceased alive on <u>Jan 17, 1956</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS—(Street, city, town, state) <u>[Address]</u>		DATE SIGNED <u>1-20-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/23/56</u>		NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL</u>		LOCATION (City, town, or county) (State) <u>BALTO, MD.</u>	
24. REC'D BY REGISTRAR <u>1/23/56</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Parker Bradley</u>		ADDRESS <u>[Address]</u>	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-45 10M

RECEIVED

APR 5 1936

BUREAU OF



326

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Catonsville</u>		<u>18 yrs. 1 mth. 23 days</u>		TOWN <u>Baltimore City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Spring Grove State Hosp.</u>				<u>531 W. 27th St. - Balto. Md.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Anna</u> <u>Bell</u> <u>McJilton</u>				OF DEATH: <u>Jan. 26</u> <u>19 56</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>white</u>	<u>widowed</u>	<u>unknown</u>	<u>83</u> yrs	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>				<u>Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>unknown</u>				<u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>unknown</u>				<u>unknown</u>		<u>Records Spring Grove State Hospital</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>42601</u>							
IMMEDIATE CAUSE		(A)		<u>Bilateral pleural effusion</u>		<u>weeks</u>	
ANTECEDENT CAUSE (B)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B)		<u>Arteriosclerotic cardiovascular disease</u>		<u>years</u>	
		DUE TO					
		(C)		<u>Generalized arteriosclerosis</u>		<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 1953, to <u>Jan. 26, 1956</u> , that I last saw the deceased alive on <u>Jan. 26, 1956</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Harold Edwards MD</u>		<u>SPRING GROVE STATE HOSPITAL</u>		<u>1-26-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>Jan 28 1956</u>		<u>Green Mount</u>		<u>Baltimore</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-24-56</u>		<u>D. W. Hedrick</u>		<u>Green Mount</u>		<u>Baltimore</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been accepted by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VII 1-55 1-55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00314

327

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>N. Y.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Timonium Md.</u>				TOWN <u>Yonkers N. Y.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York Rd. Timonium Md.</u>				STREET ADDRESS (If rural give location) <u>24 Seymour St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <u>Annie</u> (Middle) <u>Mc Millan</u> (Last)				DEATH <u>1</u> <u>31</u> <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED,	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>2-15-1878</u>	<u>77</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Housewife</u>						<u>Edenborough Scotland</u>	
12. CITIZEN OF WHAT COUNTRY?							
<u>U. S. A.</u>							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Docherty</u>				<u>Ellen Cordana</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u> <u>None</u>						<u>Annie T. Mc Millan</u> <u>Same</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>CARCINOMA OF COLON</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>SEPT.</u> , 19 <u>55</u> , to <u>JAN.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>JAN. 31</u> , 19 <u>56</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William A. Presbury</u> M.D.				DATE SIGNED <u>2-1-56</u>			
ADDRESS (Street, city, town, state) <u>Timonium</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial Removal</u>		<u>2-1-56</u>		<u>Mt. Hope Cemetery</u>		<u>Hastings on the Hudson</u> <u>N.Y.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>FEB 1 1956</u>		<u>Anna Mac Ray</u>		<u>Henry W. Jenkins and Sons Co.</u>		<u>1905 York Road, Baltimore 12, Md.</u>	

RECEIVED  
FEB 1  
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. ....

207

1. PLACE OF DEATH:

COUNTY **Baltimore** MARYLAND  
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) **Lansdowne**  
HOSPITAL OR INSTITUTION OR STREET ADDRESS **117 3 rd Ave**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Md.** COUNTY **Baltimore**  
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Lansdowne**  
STREET ADDRESS (If rural, give location) **117 Third Ave**

3. NAME OF DECEASED: (First) (Middle) (Last)  
(Type or Print) **August George Miller Sr.**

4. DATE OF DEATH: (Month) (Day) (Year)  
**Jan 10, 1956**

5. SEX: **male** 6. COLOR OR RACE: **white** 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): **married** 8. DATE OF BIRTH: **Sept. 11, 1896** 9. AGE last birthday: **59** yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **clerk** 10b. KIND OF BUSINESS OR INDUSTRY: **A. & P Tea Co.** 11. BIRTHPLACE (State or foreign country): **Baltimore** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

**James A. Miller**

14. MOTHER'S MAIDEN NAME:

**Emma Gilster**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) **yes world war**

16. SOCIAL SECURITY No.: **1 213-10-5700** 17. INFORMANT & ADDRESS: **Velma L. Miller 117 Third Ave.**

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) **Hypertensive Cardiovascular Disease**  
DUE TO  
Antecedent cause(s) (b) **Essential Hypertension**  
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

**5 yrs**

**7 yrs**

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)  
SUICIDE  
HOMICIDE  
INJURY

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED HOW DID INJURY OCCUR?  
OF While at Not while  
INJURY M. work ☐ at work ☐

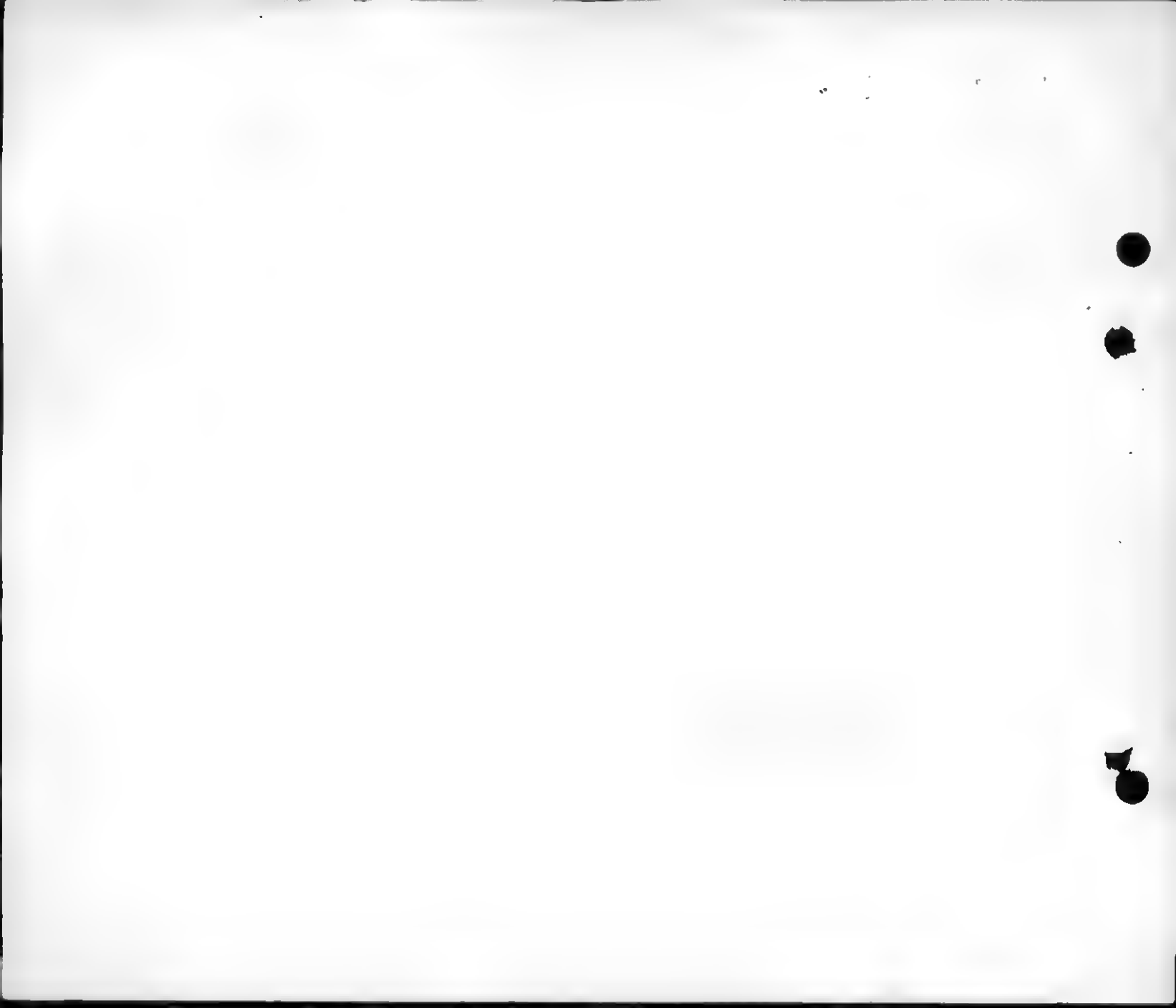
22. I hereby certify that I attended the deceased from **Oct. 1, 1951**, to **Jan. 10, 1956**, that I last saw the deceased alive on **Nov. 28, 1955**, and that death occurred at **9:15 P.m.**, from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED  
**C. Arthur Rosenberg M.D. 2436 Washington Blvd. Balto-30 Md. 1/1/56**

23. BURIAL, CREMATION REMOVAL (Specify): DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)  
**Burial 1-13-56 Baltimore National Baltimore, Md.**

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE ADDRESS  
**1/12/56 H. H. Hedrick Howard H. Hubbard, 4107 Wilkens Ave**

MARGIN RESERVED FOR BINDING



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00316

328

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>College Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>8908 Baltimore Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Florence</u> <u>Miller</u>		DEATH: <u>January 17</u> <u>1956</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>5-9-1885</u>
9. AGE last birthday <u>70</u> yrs		10. BIRTHPLACE (State or foreign country): <u>North Carolina</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		11. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10B. KIND OF BUSINESS OR INDUSTRY:		12. MOTHER'S MAIDEN NAME: <u>Louise Johnson</u>	
13. FATHER'S NAME: <u>Robert Shoemaker</u>		14. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Terminal bronchopneumonia</u>		<u>4 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Cerebrovascular hemiplegic accident</u>		<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-13-</u> <u>1956</u> to <u>1-17</u> <u>1956</u> that I last saw the deceased alive on <u>1-17</u> <u>1956</u> , and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Stella Washler</u>		DATE SIGNED <u>1-18-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>transportation</u>		DATE THEREOF <u>1/18/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Elizabethton</u>		LOCATION (City, town, or county) (State) <u>Lennox</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 18, 1956</u>		REGISTRAR'S SIGNATURE <u>T.E. Harry</u>	
24. FUNERAL DIRECTOR <u>F. Maschi son</u>		ADDRESS <u>1400 York Ave</u>	

RECEIVED

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BUREAU OF



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, File 222 2-21-56 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

00317

30

1. PLACE OF DEATH: <i>Spring Grove State Hospital</i> COUNTY <i>Balto.</i> <i>Maryland</i> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 28, Md</i> LENGTH OF STAY (in this place) <i>1. 11. 56</i> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Spring Grove State Hospital</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Md.</i> COUNTY <i>Balto.</i> CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN <i>Baltimore 28, Md</i> <i>Balto. 3001-4</i> STREET ADDRESS (If rural give location) <i>334 S. Stricker St., Balto. 29</i>	
3. NAME OF DECEASED: (First) <i>William</i> (Middle) <i>Henry</i> (Last) <i>Miller</i> (Type or Print) <i>William Henry Miller</i>		4. DATE OF DEATH: (Month) <i>1</i> (Day) <i>21</i> (Year) <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>M</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>1872-JUNE 10 1871</i>
9. AGE last birthday <i>84</i> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Painted and Bldg. R.</i>	
11. BIRTHPLACE (State or foreign country): <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>John Miller</i>		14. MOTHER'S MAIDEN NAME: <i>Margaret ELIZ KLAUS MEYER</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT'S ADDRESS: <i>GERTRUDE V. MILLER 334 S. STRICKER ST</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(A) IMMEDIATE CAUSE <i>Arteriosclerotic Heart Disease</i>			<i>Several</i>
(B) ANTECEDENT CAUSE (S) <i>General arteriosclerosis</i>			<i>Years</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>growth in oral cavity, hydration.</i>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/11</i> , 1956, to <i>1. 21</i> , 1956, that I last saw the deceased alive on <i>1. 21</i> , 1956, and that death occurred at <i>7.25 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Stellen Wachler</i>		ADDRESS <i>M.D. Spring Grove State Hospital</i> DATE SIGNED <i>1/21/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>JAN 24 1956</i>	
NAME OF CEMETERY OR CREMATORY <i>NEW CATHEDRAL</i>		LOCATION (City, town, or county) (State) <i>BALTO MD</i>	
DATE REC'D BY LOCAL REGISTRAR <i>1/24/56</i>		REGISTRAR'S SIGNATURE <i>W. H. Holrich</i>	
24. FUNERAL DIRECTOR <i>Wm. B. M. Walters</i>		ADDRESS <i>Stricker St.</i>	



1

330

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>TOWSON</u>		<u>3 YRS</u>		TOWN <u>TOWSON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>40 DUNKIRK RD.</u>				STREET ADDRESS (If rural give location) <u>40 DUNKIRK RD - 12</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JAMES</u> (Middle) <u>HENRY</u> (Last) <u>MITCHELL</u>				(Month) <u>1</u> (Day) <u>31</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>JULY 25, 1887</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>SECRETARY</u>		<u>BUILDING + LOAN</u>		<u>BALTIMORE, MARYLAND</u>		<u>U.S.A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JAMES H. MITCHELL</u>				<u>EMMA KNAUSS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>213-12-7681</u>		<u>JAMES H. MITCHELL JR</u>		<u>40 DUNKIRK RD</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A)				<u>Cerebral Hemorrhage</u>		<u>1 hour</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				(B)			
STATING UNDERLYING CAUSE LAST.				DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Arteriosclerosis and Hypertension</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 31, 1956</u> to <u>July 31, 1956</u> , that I last saw the deceased alive on <u>July 31, 1956</u> , and that death occurred at <u>2:11</u> M. from the causes and on the date stated above.							
SIGNATURE <u>William L. Helbrook, M.D.</u>				ADDRESS (Street, city, town, state) <u>5026 Roland Ave. BALTO. MD.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>BURIAL</u>		<u>2-3-56</u>		<u>LORRAINE PARK CEM</u>		<u>BALTO.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>FEB 1 1956</u>		<u>Markel Gray</u>		<u>W. J. Jenkins &amp; Co.</u>		<u>4905 YORK RD.</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

RECEIVED  
FEB 1  
BUREAU V. S.

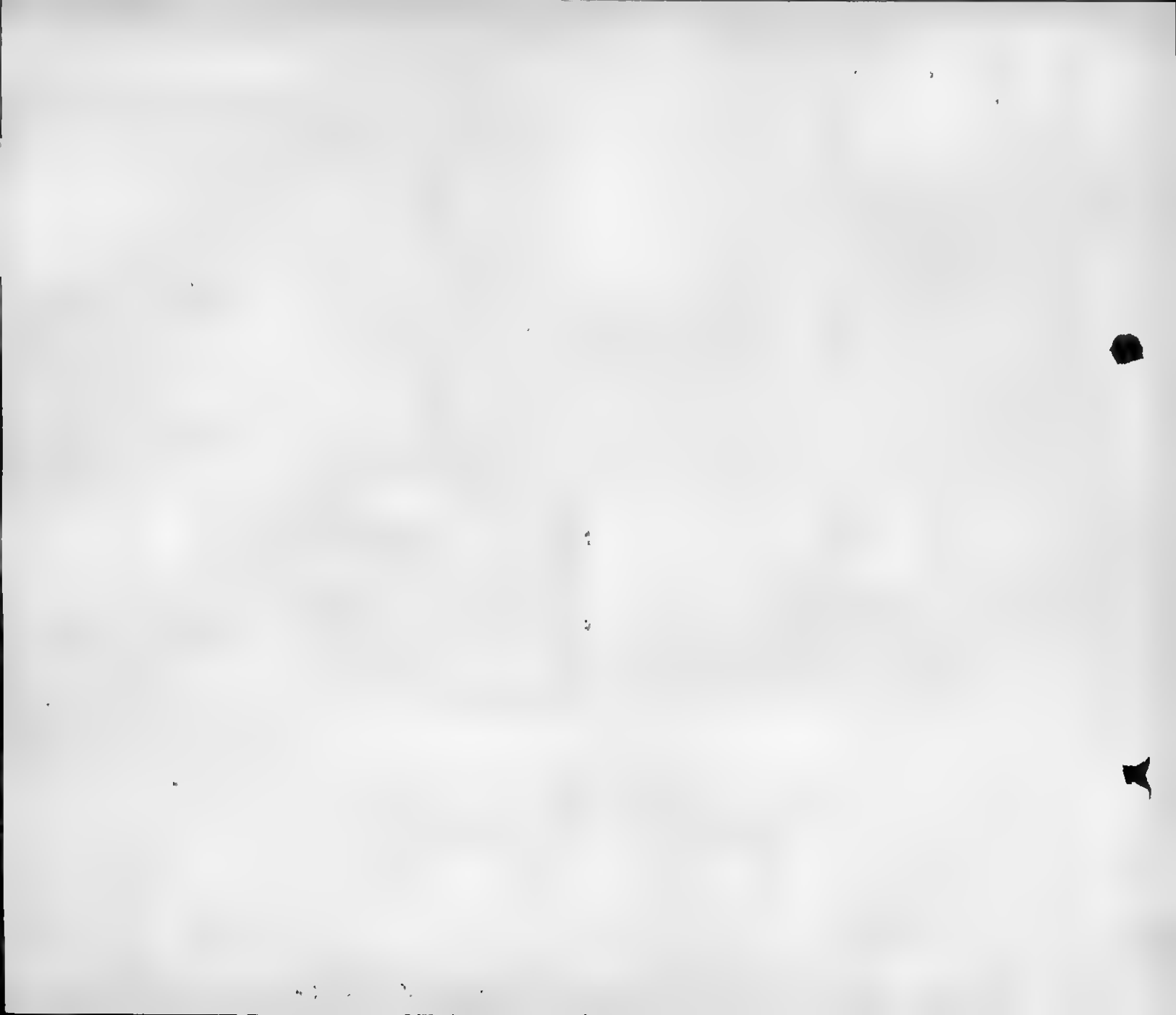
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN <u>Raspeburg</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Raspeburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1227 64th Street</u>		STREET ADDRESS (If rural give location) <u>1227 64th Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>BRUNO</u> <u>MOLL</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>Jan. 17, 1956</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Jan. 26, 1893</u>
9. AGE last birthday: <u>62</u> yrs		10. UNDER 1 YEAR: Months Days Hours Min.	11. UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk - Adv. News-Post</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Denmark</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>--- Moll</u>		14. MOTHER'S MAIDEN NAME: <u>---</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT & ADDRESS: <u>Raspeburg</u> <u>Arval Stancliff, 1227 64th Street</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Acute myocardial failure</u>			<u>2 days</u>
ANTECEDENT CAUSE (B) <u>Carcinoma of urinary bladder</u>			<u>6 mos</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Carcinoma of stomach</u>			<u>6 mos</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Oct 14, 1956</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of bladder and stomach</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct 10, 1955</u> , to <u>Jan. 16, 1956</u> , that I last saw the deceased alive on <u>Jan 16, 1956</u> , and that death occurred at <u>M, from the causes and on the date stated above.</u> SIGNATURE <u>Benz P. Abes House</u> ADDRESS <u>100 W monument St</u> DATE SIGNED <u>1/18/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>1/20/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/18/56</u>		REGISTRAR'S SIGNATURE <u>Wm. Cook, Inc.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>1217 St. Paul St.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

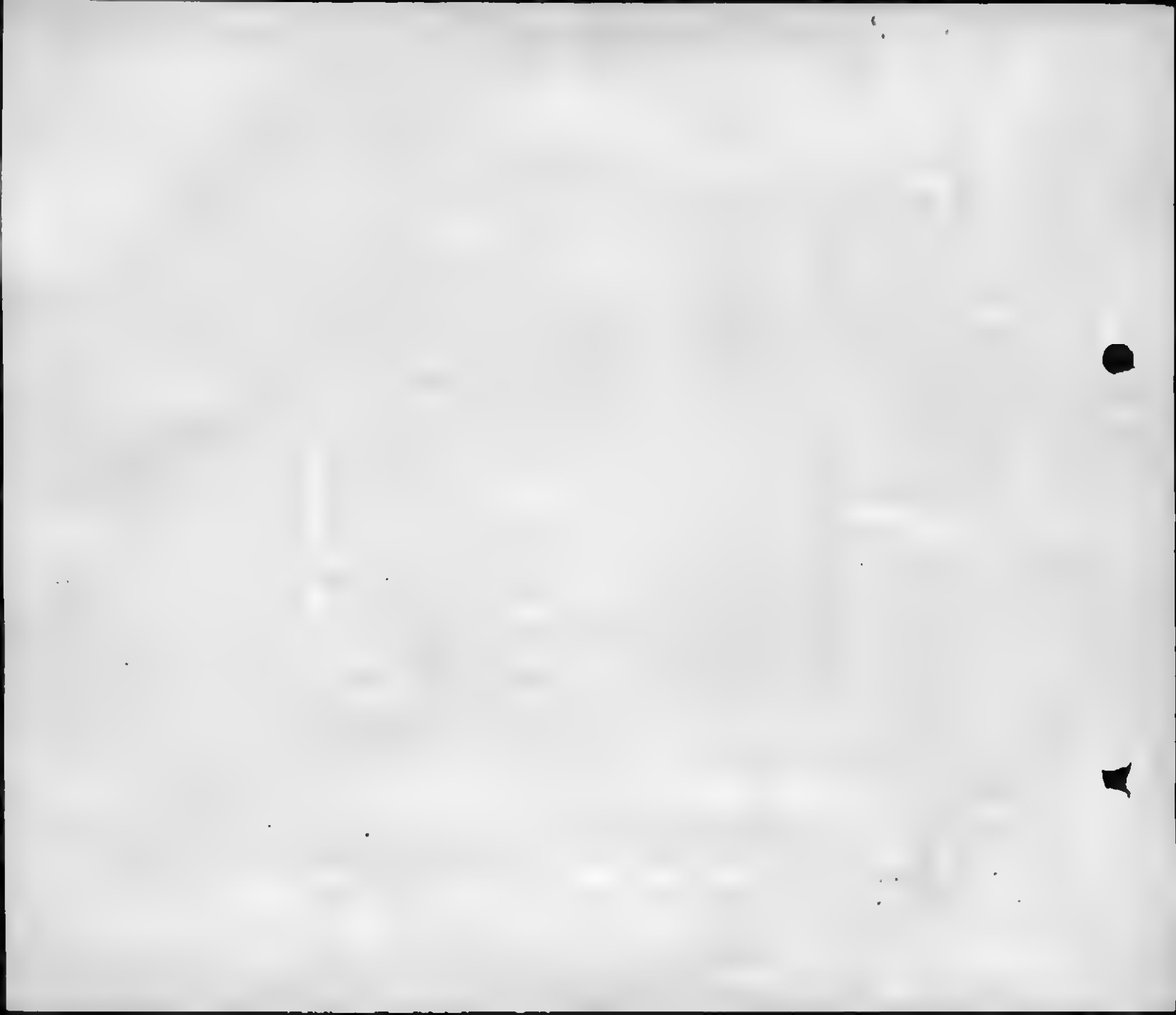
Reg. Dist. No. 38

232

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND		CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Ruxton</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> Vol-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorrenson Nursing Home</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location)		219 8. Spring Court	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JOHN</u> <u>MOORE</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>Jan. 8, 19 56</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>March 21, 1901</u>	9. AGE last birthday: <u>54</u> yrs.	IF UNDER 1 YEAR: Months <u>9</u> Days <u>18</u>	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Box Maker</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Assu Canning Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Newark, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joseph Moore</u>				14. MOTHER'S MAIDEN NAME: <u>Mary ---</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service) <u>---</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Ct. Mrs. Florence Moore, 219 S. Spring</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4 IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>						5 years	
ANTECEDENT CAUSE (S) (B) <u>Myocardial hypertrophy</u>						5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Cerebral accident old.</u>						unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Mental confusion</u>						unknown	
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION: <u>no operation</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY, street, office bldg., etc.) <u>no injury</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>no injury</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>no injury</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>no injury</u>			
22. I hereby certify that I attended the deceased from <u>Dec 30, 1955</u> , to <u>Jan 5, 19 56</u> that I last saw the deceased alive on <u>Jan 5, 19 56</u> , and that death occurred at <u>I . . .</u> from the causes and on the date stated above.							
SIGNATURE <u>J. G. Hedrick</u>				M. D. <u>Wm Cook D.C.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>1/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/10/56</u>		REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Wm Cook D.C.</u>		ADDRESS <u>1217 St. Paul St.</u>	

MARGIN RESERVED FOR FINDINGS

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





199

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

COUNTY BALTIMORE MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) (in this place)  
 TOWN DUNBAR  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 2900 DUNBAR RD

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY BALTO  
 CITY (If outside corporate limits write RURAL and give nearest town)  
 OR  
 TOWN SPARROW POINT X  
 STREET (If rural give location)  
 ADDRESS 1254 HADDAWAY RD

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

CHRISTINEOLAMORRIS

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

JAN231956

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

## 8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.  
 yrs. Months Days Hours Min.FEMALEWHITESINGLEAUG 15, 1955558195610a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): BALTIMORE MD12. CITIZEN OF WHAT COUNTRY? U.S.A.

## 13. FATHER'S NAME:

WALLACE MORRIS

## 14. MOTHER'S MAIDEN NAME:

LEOLA SHIFFLETT15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  
NO

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

WALLACE MORRIS 1254 HADDAWAY RD

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pneumonia, Cerebral  
 DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Interval Between Onset And Death

24 hrs.

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 22 Jan, 1956 to 23 Jan, 1956, that I last saw the deceasedalive on 22 Jan, 1956, and that death occurred at 6 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

Jan 23-1956 William M KellyULLRICH FUNERAL HOME 2112 DUNBAR

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 25 1956

BUREAU V. S.

333

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00322

Item 18 Film G193 2-23-56 ams

## CERTIFICATE OF DEATH

Reg. Dist. No.

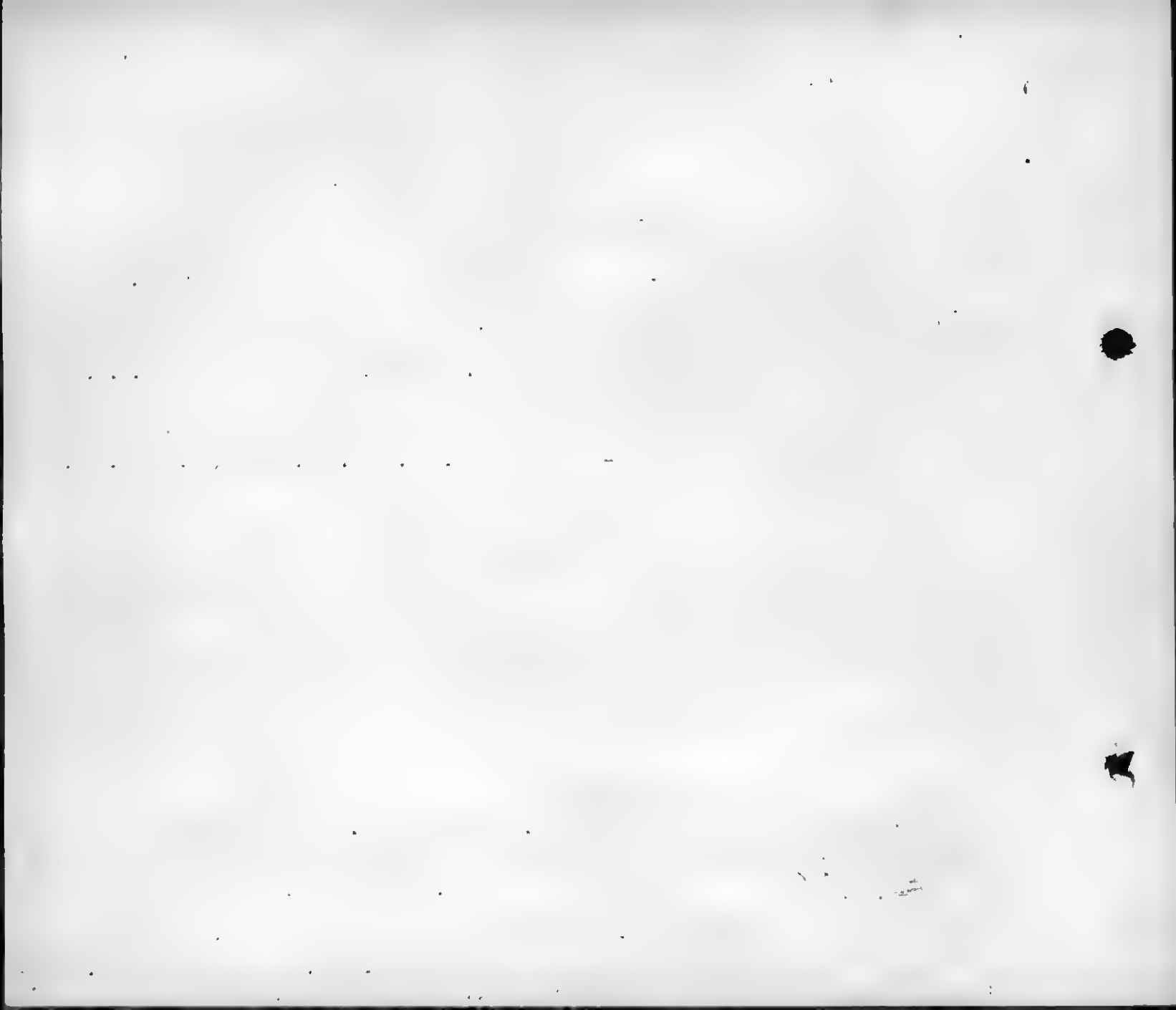
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>BALTIMORE</b> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>FORT HOWARD</b> LENGTH OF STAY (in this place) <b>32 Days</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STATE <b>MARYLAND</b> COUNTY <b>CALVERT</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>GWINGS, MARYLAND</b> STREET ADDRESS (If rural give location) <b>GWINGS, MARYLAND</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>GEORGE B. MORSELL</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>January 14, 1956</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>MARRIED</b>		8. DATE OF BIRTH. <b>JULY 20, 1913</b>	
9. AGE last birthday <b>42</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>FARMER</b>		10a. KIND OF BUSINESS OR INDUSTRY: <b>TOBACCO FARM</b>		11. BIRTHPLACE (State or foreign country): <b>MT. HARMONY, MARYLAND</b>	
13. FATHER'S NAME: <b>HENRY MORSELL</b>				14. MOTHER'S MAIDEN NAME: <b>IDA HALL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service): <b>YES</b> <b>WW-11</b>				16. SOCIAL SECURITY NO. <b>217-28-1829</b>		17. INFORMANT & ADDRESS: <b>VET. ADM. HOSP., FT. HOWARD, MD. (CLIN. REC.)</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						3 MONTHS	
(A) IMMEDIATE CAUSE <b>CEREBRAL HEMORRHAGE, LEFT</b>						UNKNOWN	
(B) ANTECEDENT CAUSE (S) <b>GLIOMA OF THE PONS WITH EXTENSION INTO THE LEFT CEREBRAL HEMISPHERE</b>						UNKNOWN	
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:						19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 13, 1955, to JAN. 14, 1956, and that death occurred at 11:40 AM, from the causes and on the date stated above.							
SIGNATURE <b>D. D. MARK</b>				ADDRESS <b>M. D. VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>1-15-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1/18/56</b>		NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		LOCATION (City, town, or county) (State) <b>Sunderland, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>6-56</b>		REGISTRAR'S SIGNATURE <b>Pinkey Sewell</b>		24. FUNERAL DIRECTOR <b>Charles B. Law</b>		ADDRESS <b>802-4 Madison Ave. Balto. Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

Released to:



334

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Ruxton</u>				TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorensen Nursing Home</u> <u>7912 Ruxway</u>				STREET ADDRESS (If rural give location) <u>5813 Bellona Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Pauline</u> (Middle) <u>Marie</u> (Last) <u>MOSS</u> (Also) <u>MOSS</u>				(Month) <u>January</u> (Day) <u>2</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>11/22/1873</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					<u>Missouri</u>		<u>U.S.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Schleifer</u>				<u>Eva Bingold</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Chas. T. Moss 5813 Bellona Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				<u>Cerebral Hemorrhage</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				<u>arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>Hypertension</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>1 day</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-31-54</u> to <u>1-2-56</u> , that I last saw the deceased alive on <u>1-2-56</u> , and that death occurred at <u>12</u> M. from the causes and on the date stated above.							
SIGNATURE <u>James G. Siffert</u>				ADDRESS (Street, city, town, state) <u>Baltimore Md</u> DATE SIGNED <u>1-3-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/11/56</u>		<u>St. Mary's, Govens</u>		<u>Baltimore Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>John S</u>		<u>Maich Grays</u>		<u>H.W. Jenkins and Sons Co.</u>		<u>York Rd.</u>	

**1**

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



## MARYLAND STATE DEPARTMENT OF HEALTH

00324

335

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH COUNTY <u>Baltimore</u> <u>Sorensen Nursing Home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u></u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood, Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Riderwood</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorensen Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>434 E. Biddle Street</u>	
3. NAME OF DECEASED (First) <u>Mary</u> (Middle) <u>C</u> (Last) <u>Mullin</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>6</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 18, 1879</u>
9. AGE last birthday <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Martin J. Mullin</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Heaphy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT AND ADDRESS <u>Richard H. Lerch 265 Stanmore Road</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute, massive myocardial infarction

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Myocarditis with(c) Hypertrophy myocardium

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Interlobular pneumonia generalized.

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>no operation</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>no injury</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>none</u>	(CITY OR TOWN) <u>none</u> (COUNTY) <u>none</u> (STATE) <u>none</u>
SUICIDE <u>none</u>	INJURY <u>none</u>	HOW DID INJURY OCCUR? <u>none</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>no injury</u> m. <u></u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	

22. I hereby certify that I attended the deceased from Jan. 10, 1956, to Jan. 10, 1956, that I last saw the deceasedalive on Jan. 10, 1956, and that death occurred at 5:40 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/9/56</u>	NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State) <u></u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>JAN 8 - 1956</u>	24. FUNERAL DIRECTOR <u>W. H. Meyer Son 8057 Calvert St</u>	ADDRESS <u></u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. S.

RECEIVED



MARYLAND

00325  
STATE DEPARTMENT OF HEALTH

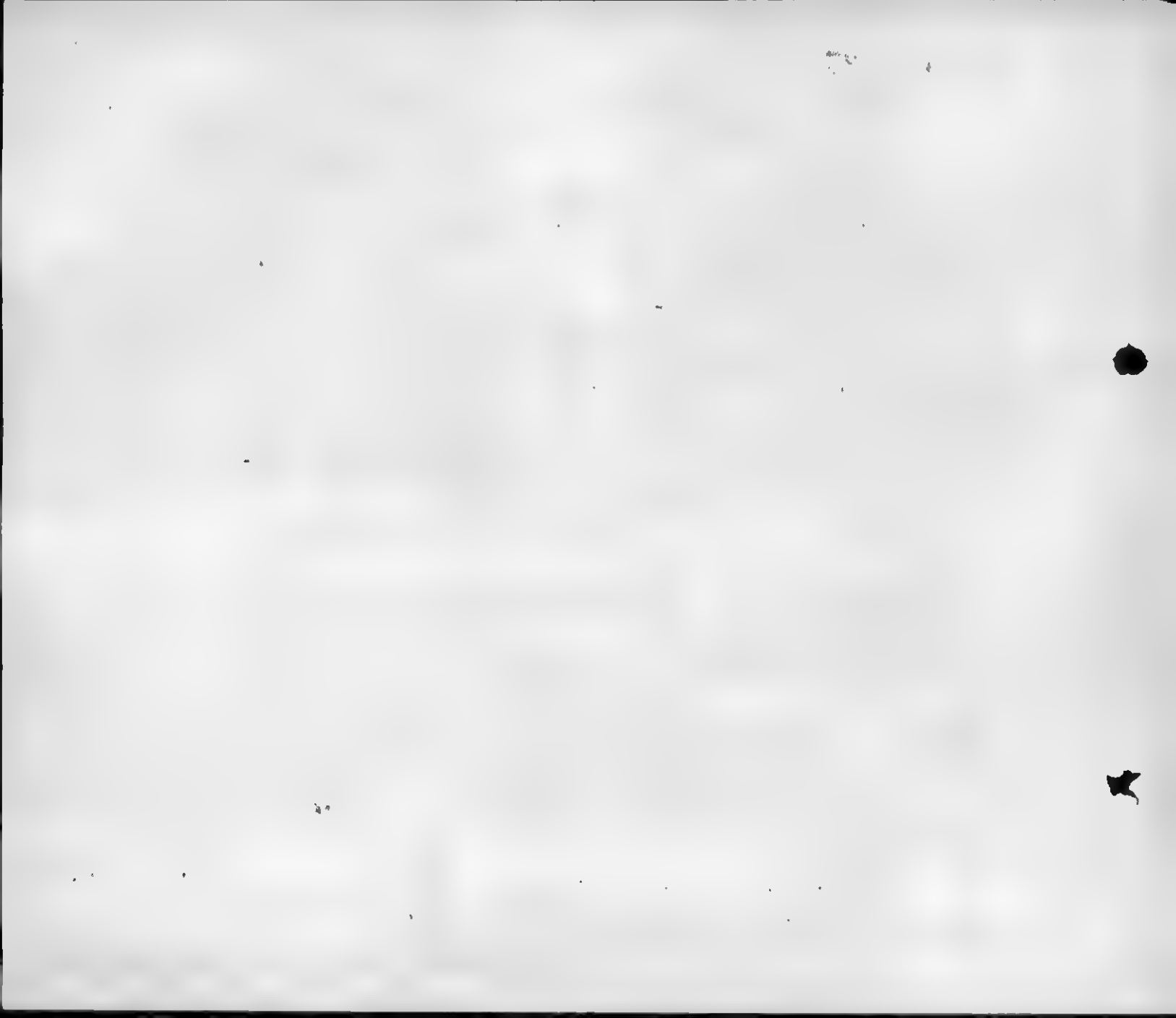
236

## CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MD</b> COUNTY <b>BALTO</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Cockeysville</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Cockeysville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>5 Shawan Rd</b>		STREET ADDRESS (If rural, give location) <b>5 Shawan Rd</b>	
3. NAME OF DECEASED (Type or Print) <b>Elizabeth MARGARET MURPHY</b>		4. DATE OF DEATH <b>JAN 4 1956</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>JAN 23 1883</b>
9. AGE last birthday <b>72</b> yrs.		10. If under 1 year: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Jacobs</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Wolfe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If year, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT AND ADDRESS <b>Mrs Joseph L Ackerman Same</b>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
Immediate cause (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH	
Antecedent cause(s) (b).... <b>Hypertensive Cardiovascular Disease</b>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)....			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPTSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>12/2/1955</b> , to <b>1/4/1956</b> , that I last saw the deceased alive on <b>12/30/1955</b> , and that death occurred at <b>9 P.m.</b> , from the causes and on the date stated above.			
SIGNATURE <b>Dr. Quinn</b>		ADDRESS <b>1927 York Rd, Timonium</b>	
DATE SIGNED <b>1/4/56</b>			
23. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>BURIAL</b>		DATE <b>JAN 7 1956</b>	
NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		LOCATION (City, town, or county) <b>Balto MD</b>	
DATE REC'D BY LOCAL REG. <b>1/5/56</b>		REGISTRAR'S SIGNATURE <b>W. H. Hinkins</b>	
24. FUNERAL DIRECTOR <b>H. Hinkins</b>		ADDRESS <b>4905 York Rd</b>	

MARGIN RESERVED FOR BINDING



337

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>MT Wilson</u>	<u>2 yrs 8 months</u>	TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MT Wilson State Hospital</u>		STREET ADDRESS (If rural give location) <u>308 N. Broadway Balto 31</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>EYRIA</u>	(Middle) <u>RANDELLS</u>	(Last) <u>MURPHY</u>	DATE OF DEATH <u>1 - 29 1956</u>
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>
8. DATE OF BIRTH: <u>5-5-03</u>		9. AGE last birthday <u>52</u> yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>STEAM FIVE FITTER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>OWEN YACHT CO.</u>	
11. BIRTHPLACE (State or foreign country): <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William David Murphy</u>		14. MOTHER'S MAIDEN NAME: <u>Flora Mae Eric</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO.: <u>833-09-0087</u>	
17. INFORMANT & ADDRESS: <u>Frances Murphy wife 308 N. Broadway Balto 31</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>		<u>2 yrs 10 mos</u>	
ANTECEDENT CAUSE (B) <u></u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5-13-1953</u> , to <u>1-29-1956</u> , that I last saw the deceased alive on <u>1-29-1956</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>William M. Newell</u>		DATE SIGNED <u>1-29-56</u>	
ADDRESS <u>Mount Wilson Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/30/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Arsons W. Va.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 30, 1956</u>		REGISTRAR'S SIGNATURE <u>William M. Newell</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell &amp; P. K. Newell</u>		ADDRESS <u></u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

37-1000

1956

U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

**INSTRUCTIONS**

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be delivered for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

333

CERTIFICATE OF DEATH

00327

Reg. Dist. No. 31

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Woodlawn</u>		LENGTH OF STAY (in this place) <u>10 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1932 Summit Ave</u>				STREET ADDRESS (If rural give location) <u>1932 Summit Ave</u>			
3. NAME OF (First) (Middle) (Last) <u>JOHN- EDWARD- MYERS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 24 1956</u>			
5. SEX <u>M</u>	6. CO. OR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 28-1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William A Myers</u>				14. MOTHER'S MAIDEN NAME <u>Mary E Nolte</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Mrs Samuel Myers - Reisterstown Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>				INTERVAL BETWEEN ONSET OF DEATH <u>48 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic C.V. Disease with</u>				<u>2-5 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cardiac De-compensation</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 21, 1949</u> , to <u>Jan 24, 1956</u> , that I last saw the deceased alive on <u>Jan 21, 1956</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Marion E. Stroh</u>				ADDRESS (Street, city, town, state) <u>M.D. 48 1/2 mi. Reisterstown, Md.</u>		DATE SIGNED <u>1/24/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 27/56</u>		NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dr. Wm. E. Martin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Tipton</u>		ADDRESS <u>Hampstead Md</u>	
DATE <u>Jan. 26, 1956</u>							

1944

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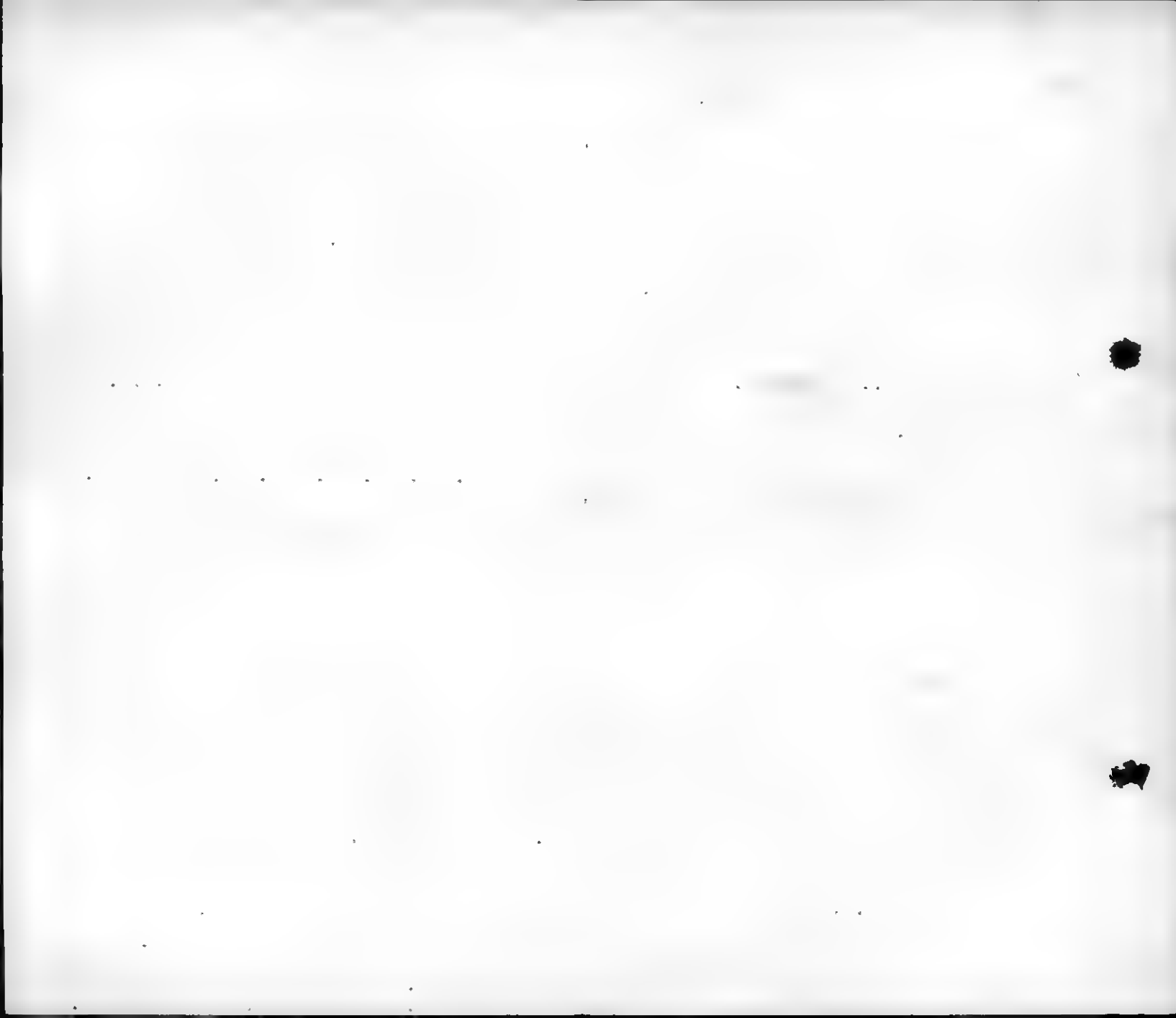
1944

339 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00328  
 CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Fort Howard</u>	<u>1 Day</u>	TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>430 N. Clinton Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>JAMES F. NEARY</u>		OF DEATH: <u>January 30 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>8/7/93</u>
9. AGE last birthday <u>62</u> yrs.		10. AGE last birthday (If under 1 year, if under 24 hrs. Months Days Hours Min.)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired, state so) <u>Retired Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Chemical Plant</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James P. Neary</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Muldowney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW-II</u>		16. SOCIAL SECURITY No. <u>212 14 1973</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>CARCINOMA OF THE HYPOPHARYNX WITH PERFORATION OF THE LARYNX</u>		<u>UNKNOWN</u>
ANTECEDENT CAUSE (B) <u>CARCINOMA OF PROSTATE</u>		<u>UNKNOWN</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>9-30-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>(1) Bilateral orchidectomy (2) Tracheotomy</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Jan. 29, 1956</u> to <u>Jan. 30, 1956</u> , that I last saw the deceased <u>alive and breathing</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.				
SIGNATURE <u>D. D. MARK, M.D.</u>		ADDRESS <u>VAH, Fort Howard, Md.</u>		DATE SIGNED <u>1/31/56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>2/2/56</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-7-56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>John A. Moran Funeral Home</u>		ADDRESS <u>3000 E. Baltimore St. Baltimore, Md.</u>





**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

**VS AISC 1-55 10M**

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

340

## CERTIFICATE OF DEATH

00329

Reg. Dist. No. .... 37

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Timonium</u>		TOWN <u>Timonium</u>		STREET ADDRESS		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>133 Greenmeadow Drive</u>				HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>133 Greenmeadow Drive</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Arthur Nichols</u>				<u>Jan. 7, 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Nov. 14, 1886</u>	<u>69</u> yrs.	Months	Days	Hours
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Electrician</u>			<u>Electrical</u>	<u>Arglitte, Kentucky</u>		<u>U. S. A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Jesse Nichols</u>				<u>Alydia Burton</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>232-12-9092</u>		<u>Mrs. Sarah Nichols-133 Greenmeadow Dr.</u>			
<b>18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>19. MEDICAL CERTIFICATION</b>			
<u>331X</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
<b>22. I hereby certify that I attended the deceased from <u>JAN. 3<sup>rd</sup>, 1956</u>, to <u>JAN. 6<sup>th</sup>, 1956</u>, that I last saw the deceased alive on <u>JAN. 6<sup>th</sup>, 1956</u>, and that death occurred at <u>6:30 PM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>		<b>M.D.</b>		<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<u>M. K. Quinn</u>				<u>York Rd, Timonium, Md.</u>		<u>1/9/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b>	
<u>Burial</u>		<u>Jan. 10, 1956</u>		<u>Moreland Memorial Park</u>		<u>Baltimore, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
		<u>Mrs. Anne MacRae</u>		<u>Sarah's Funeral Home - 7401 Belair Rd.</u>			
<b>DATE</b>							



341

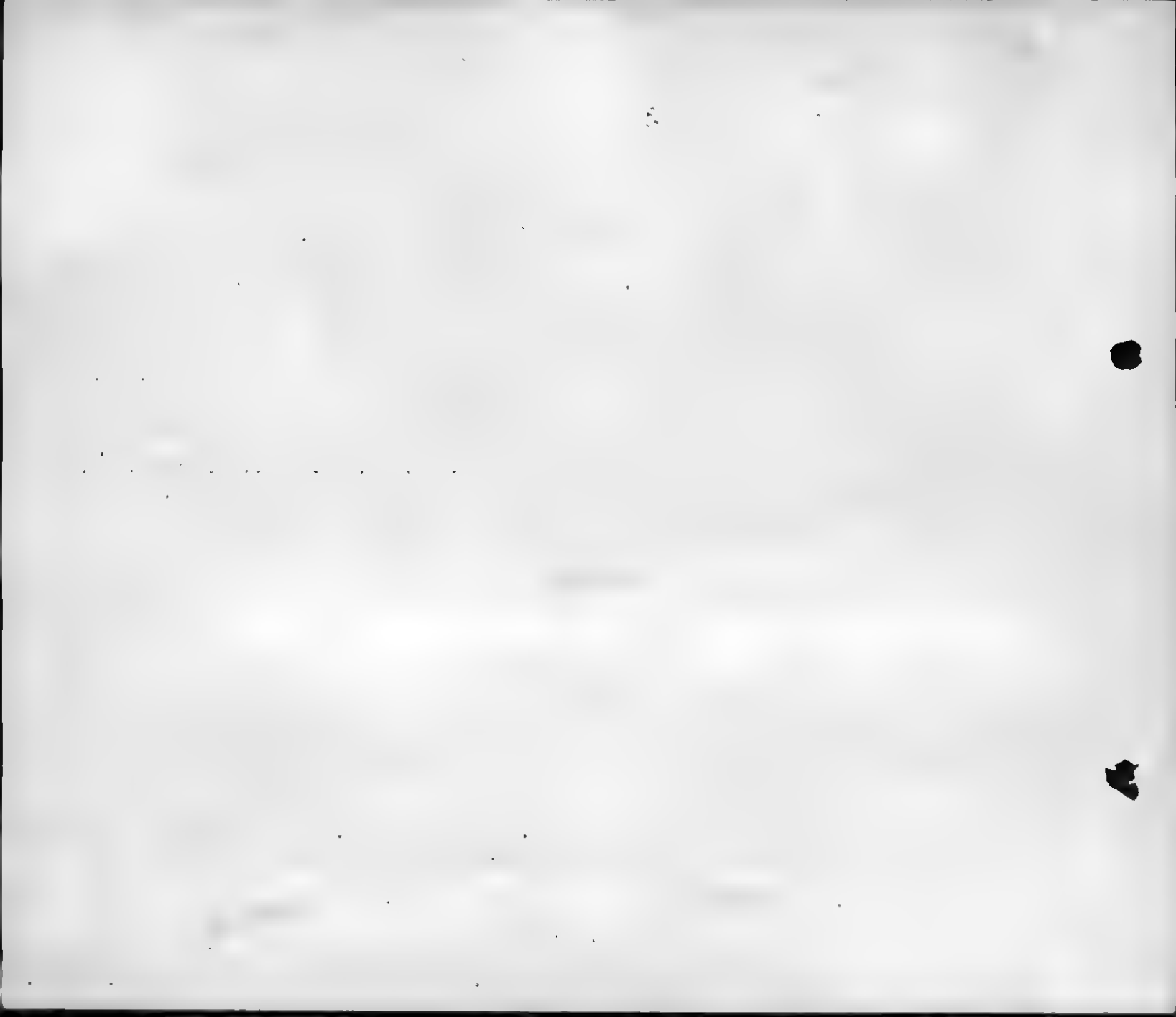
## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
TOWN <u>Fort Howard</u>		<u>3 Days</u>		STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				<u>1500 N. Linwood Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>WILLIAM A. O'BRIEN</u>				<u>January 29, 1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>9/24/99</u>	
9. AGE last birthday <u>56 yrs</u>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Civ. Policeman</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
13. FATHER'S NAME: <u>John Joseph O'Brien</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
14. MOTHER'S MAIDEN NAME: <u>Julia Hyland</u>				17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>Yes WW-I</u>				16. SOCIAL SECURITY NO. <u>216-30-7362</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
(A) IMMEDIATE CAUSE							
(B) ANTECEDENT CAUSE (S)							
DUE TO <u>THROMBOSIS OF ABDOMINAL AORTA WITH GANGRENE OF THE LOWER EXTREMITIES</u>						<u>1 WEEK</u>	
DUE TO <u>MURAL THROMBOSIS, LEFT VENTRICLE</u>							
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>HEALED MYOCARDIAL INFARCT LEFT VENTRICLE</u>						UNKNOWN	
19A. DATE OF OPERATION: <u>1-26-56</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Aortotomy</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>VA</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
2. I hereby certify that I attended the deceased from Jan. 26, 1956, to Jan. 29, 1956, and that death occurred at 3:20 PM, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>1/30/56</u>			
D. D. MARK, M.D.				VAH, Fort Howard, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-2-56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-1-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Im. Cook-Blight Inc</u>		ADDRESS <u>6009 Harford Rd., Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

00331

Reg. Dist. No. ....

1. PLACE OF DEATH— COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <u>MD.</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TIMONIUM</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TIMONIUM</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2340 YORK RD.</u>		STREET ADDRESS (If rural, give location) <u>2340 YORK RD.</u>	
3. NAME OF DECEASED (Type or Print) <u>SARAH JANE O'NEILL</u>		4. DATE OF DEATH (Month) <u>JAN.</u> (Day) <u>14</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>?</u>
9. AGE last birthday <u>approx 80 yrs.</u>		10. If under 1 year: Months <u>?</u> Days <u>?</u> Hours <u>?</u> Min. <u>?</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN OWEN O'NEILL</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELLEN O'NEILL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>GEORGE D. O'NEILL, 6206 PINEHURST RD.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> Immediate cause (a) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 YRS.</u>
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>William A. Priestbury M.D.</u>		ADDRESS <u>Timonium</u>	
DATE SIGNED <u>1/14/56</u>			
23. CREMATION (If yes, specify) <u>BURIAL</u>		DATE THEREOF <u>1-17-56</u>	
NAME OF CEMETERY OR CREMATORY <u>CATHERBARK</u>		LOCATION (City, town, or county) (State) <u>BALTO.</u>	
24. FUNERAL DIRECTOR <u>Dr. Redmill</u>		ADDRESS <u>Greenmount &amp; 32nd St</u>	



343

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Towson  
 TOWN Towson LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Sheppard & Enoch Pratt Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore  
 OR TOWN Baltimore

STREET ADDRESS (If rural give location)  
3348 Keswick Road

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

CarrollCourtneyOsborne

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

Jan. 6 1956

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS  
68 yrs. Months Days Hours Min.

MaleWhiteMarried1/27/87

10a. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (State or foreign country): Baltimore County, Md.

12. CITIZEN OF WHAT COUNTRY? U S A

## 13. FATHER'S NAME:

?

## 14. MOTHER'S MAIDEN NAME:

?

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  
unk

## 16. SOCIAL SECURITY No.:

212-32-1189

## 17. INFORMANT &amp; ADDRESS:

Employment Record - Sheppard-Pratt Hospital

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cardio-vascular Disease - Coronary Occlusion

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) CardioVascular Disease - Coronary Occlusions

DUE TO

(c) Arteriosclerosis

Interval Between Onset and Death  
2 hrs.  
15 yrs  
unk

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

None

## 20. AUTOPSY ?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)  
None

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
 OF INJURY None m.

INJURY OCCURRED  
 While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3:30 to Jan 6, 1956, that I last saw the deceased

alive on Jan 6, 1956, and that death occurred at 3:30 PM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR  
January 7, 1956

REGISTRAR'S SIGNATURE

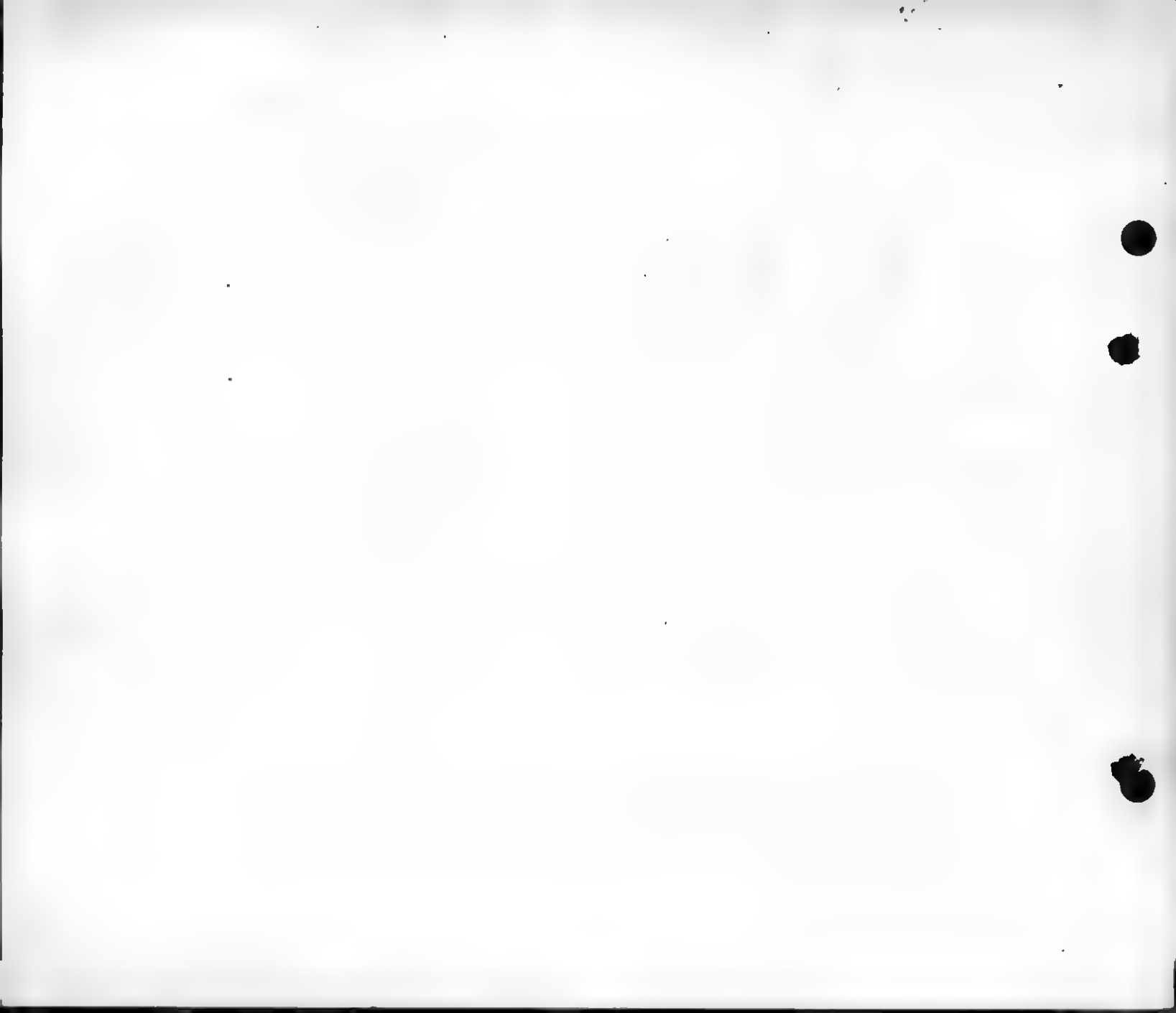
R.W.

## 24. FUNERAL DIRECTOR

✓ Paul E. L. Heman ADDRESS 3615-17 Chestnut

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not collect age is especially important. Physicians: please write the causes of death clearly and legibly.





## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: 344  
 COUNTY BALTIMORE MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE  
 OR TOWN CATONSVILLE  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS CATON RIDGE HOME

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 STATE MARYLAND COUNTY BALTO  
 CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE  
 OR TOWN BALTIMORE  
 STREET ADDRESS (If rural give location) 1101 ANGELESA ST

3. NAME OF DECEASED: (First) (Middle) (Last)  
PAUL OTT

4. DATE OF DEATH: (Month) (Day) (Year)  
Jan 20 1956

5. SEX: MALE 6. COLOR OR RACE: WHITE 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED 8. DATE OF BIRTH: AUG 23-1874 9. AGE last birthday: 81 yrs. Months Days Hours Min.

10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: IRON MOLDER 11. KIND OF BUSINESS OR INDUSTRY: FOUNDRY 12. CITIZEN OF WHAT COUNTRY: PENNA

13. FATHER'S NAME: GEORGE OTT 14. MOTHER'S MAIDEN NAME: MARGARET WAGNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO (If Yes, give war or dates of service) 16. SOCIAL SECURITY No.: 17. INFORMANT & ADDRESS: PAUL OTT JR - 1101 ANGELESA ST

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  
 Immediate cause (a) Fracture Subtrochanteric femur left.  
 Antecedent causes (s) (b) fracture 12ft.  
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)

11. OTHER SIGNIFICANT CONDITIONS  
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Dec 1955 19b. MAJOR FINDINGS OF OPERATION: Fracture Subtrochanteric femur left 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT (Specify) Accident PLACE (Home, farm, factory, street, office, bldg., etc.) Home (CITY OR TOWN) Catonsville (COUNTY) 28 MD (STATE)  
 TIME (Month) (Day) (Year) (Hour) OF INJURY Dec 27 1955 11:30 AM INJURY OCCURRED While at Work ☐ Not While At Work ☒ HOW DID INJURY OCCUR? Fell to floor at home

22. I hereby certify that I attended the deceased from 1954 to Jan 1956, that I last saw the deceased alive on 16 Jan, 1956, and that death occurred at 11:30 P.M., from the causes and on the date stated above.  
 SIGNATURE Wm. Scott A.D. (Degree or title) ADDRESS 1707 Edmondson Ave. Catonsville 28 MD DATE SIGNED 1/21/56

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL DATE THEREOF JAN 27 1956 NAME OF CEMETERY OR CREMATORY SACRED HEART LOCATION (City, town, or county) (State) DUNDALK MD  
 DATE REC'D BY LOCAL REGISTRAR Jan 24 1956 REGISTRAR'S SIGNATURE P. B. Perry 24. FUNERAL DIRECTOR ADDRESS ULLRICH FUNERAL HOME - 2112 DUNDALK Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BOURBAU V. S.

AM 3 1956

RECEIVED

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

345

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Balto.</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Balto</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Essey</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Essey zone 21</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>368 Edgewater Apt.</i>				STREET ADDRESS <i>368 Edgewater Apt.</i>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Phoebe Parks</i>				<b>4. DATE OF DEATH</b> (Month) <i>1</i> (Day) <i>22</i> (Year) <i>1956</i>			
<b>5. SEX</b> <i>F</i>	<b>6. COLOR OR RACE</b> <i>W</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>married</i>	<b>8. DATE OF BIRTH</b> <i>May 18, 1895</i>	<b>9. AGE last birthday</b> <i>60</i> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>House wife</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>None</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>North Carolina</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <i>Mrs. M. Adams</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Marta E. Church</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No.</i>		<b>16. SOCIAL SECURITY NO.</b> <i>unknown</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Albert Parks (same)</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <i>Malignant carcinoma of</i>						INTERVAL BETWEEN ONSET AND DEATH <i>4 mo.</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>gall bladder</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <i>Oct 1955</i>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <i>Carcinoma gall bladder, inoperable</i>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>21d. HOW DID INJURY OCCUR?</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
<b>22. I hereby certify that I attended the deceased from</b> <i>Sept 1955</i> , to <i>Jan 22, 1956</i> , that I last saw the deceased alive on <i>Jan 22, 1956</i> , and that death occurred at <i>8:15 P.M.</i> from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>Louis Semeroff</i>		<b>DATE THEREOF</b> <i>1-23-56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>M.D. 1437 Fawcett Ave. Balto Md</i>		<b>LOCATION</b> (City, town, or county) (State) <i>Wm. H. Smith Co. Md.</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Removal</i>		<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Edith Hurley</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Wm. H. Smith</i>	
<b>DATE</b> <i>1-24-56</i>				<b>ADDRESS</b> <i>1417 Eastern Ave</i>			

RECEIVED  
U. S. AIR FORCE

JAN 23 1956

RECEIVED  
U. S. AIR FORCE

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

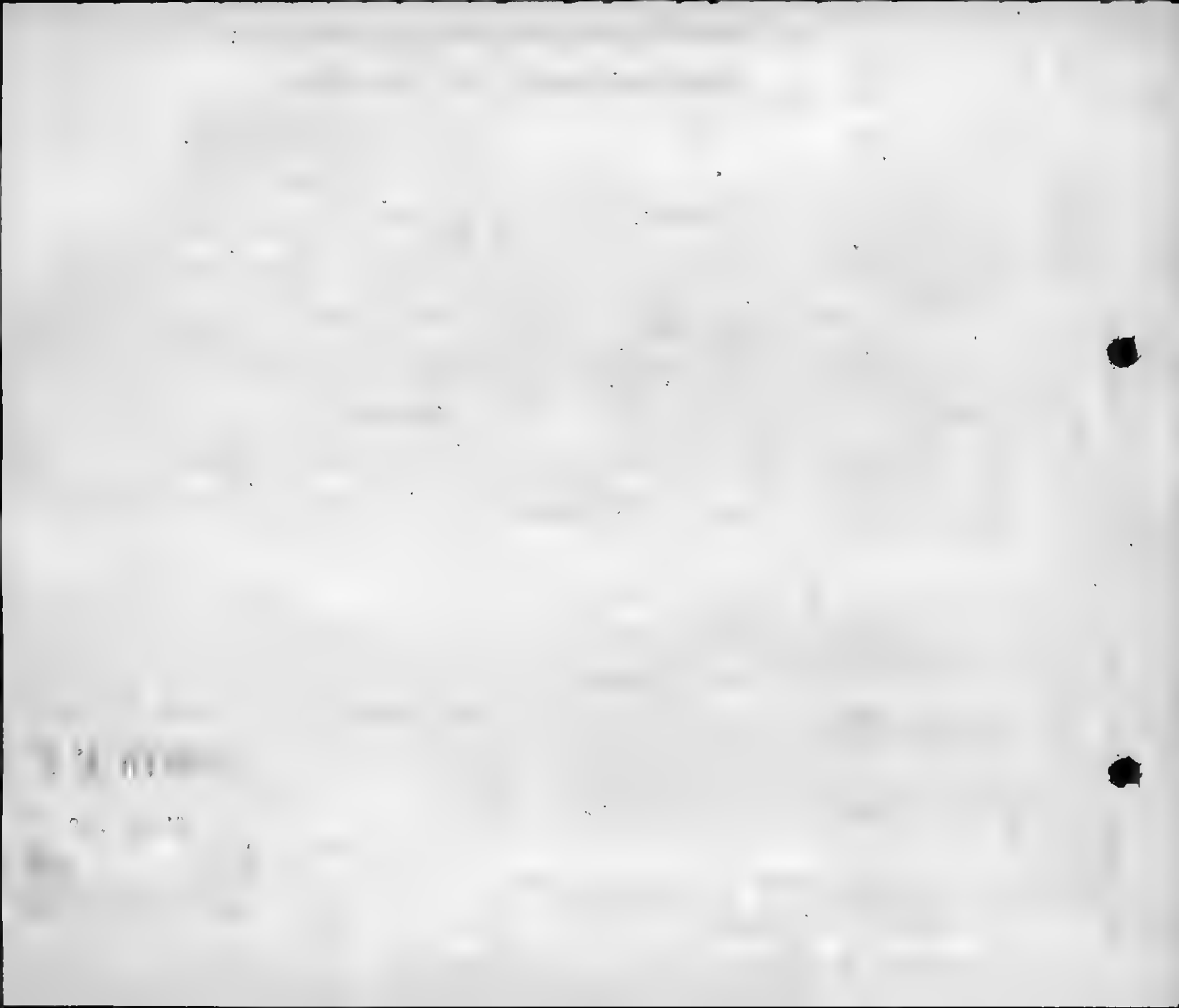
00335

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Film G-191 1/27/56

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SPARROWS POINT</u>		LENGTH OF STAY (In this place) <u>64</u> days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SPARROWS POINT</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1951 ELLIOTT 68 Admiral Blvd.</u>				STREET ADDRESS (If rural give location) <u>915 E ST.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ISABELLA</u> (Middle) <u>—</u> (Last) <u>PATERSON</u>				(Month) <u>1</u> (Day) <u>22</u> (Year) <u>1956</u>			
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>22 SEPT. 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>JOHN PATERSON</u>				14. MOTHER'S MAIDEN NAME <u>ALICE DRESSER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>MRS. A. SIDNEY HACKMAN - HOME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ventricular Fibrillation (probable)</u>				<u>2 hours</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u>				<u>at least 10 yrs.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 1, 1955</u> to <u>Jan. 22, 1956</u> that I last saw the deceased alive on <u>Dec. 20, 1955</u> and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>David Charles M.D.</u>				ADDRESS (Street, city, town, state) <u>914 D Street Sparrows Point, Md.</u>		DATE SIGNED <u>Jan. 19, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-25-56</u>		NAME OF CEMETERY OR CREMATORY <u>LODOWEN PARK</u>		LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>	
24. REC'D BY REGISTRAR <u>Jan 24-56</u>		REGISTRAR'S SIGNATURE <u>Dawson S. Farley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Burke Paddy, Hurdell, Md.</u>		ADDRESS	



345

## CERTIFICATE OF DEATH

00336

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE HOME OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>201 S. Symington Ave</u>				ADDRESS <u>201 S. Symington Ave.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>EMMA MAY PAYNE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 24 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-22-1879</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Meeth</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Tribbie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Herbert Payne, Ellicott City, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CONGESTIVE CARDIAC FAILURE</u>						<u>CHRONIC</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>AORTIC STENOSIS</u>						<u>CONGENITAL</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>NEPHROSCLEROSIS</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>YEARS</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> N. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAY</u> , 19 <u>53</u> , to <u>JAN.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>JAN 24</u> , 19 <u>56</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ronald E. Taylor</u>		M.D. <u>Ellicott City</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>1-25-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-27-56</u>		NAME OF CEMETERY OR CREMATORY <u>Salem Lutheran</u>		LOCATION (City, town, or county) (State) <u>Catonsville, Md</u>	
24. REC'D BY REGISTRAR <u>1-27-56</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Nabb &amp; Son, Catonsville, Md.</u>		ADDRESS	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

5 1 1



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00337

247

## CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH: COUNTY <u>MT. WILSON</u> <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>17 months</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MT. WILSON STATE Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> STREET ADDRESS (If rural give location) <u>1837 WEST PRATT ST.</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MILTON</u> <u>BARTH</u> <u>PELTZ</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>JAN.</u> <u>22</u> <u>1956</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>2.28.1904</u>	
9. AGE last birthday: <u>51</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Auto-Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>SELF EMPLOYED</u>		11. BIRTHPLACE (State or foreign country): <u>NORFOLK, VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME: <u>MILTON PELTZ</u>			
14. MOTHER'S MAIDEN NAME: <u>MOLLY SCHLEY</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>212-34-5737</u>				17. INFORMANT & ADDRESS: <u>MT Wilson State Hospital, Mt Wilson, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>FAR ADVANCED PULMONARY TUBERCULOSIS</u>							
ANTECEDENT CAUSE (B) <u>MILINARY TUBERCULOSIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5.19.1956</u> to <u>1.22.1956</u> , that I last saw the deceased alive on <u>1.22.1956</u> , and that death occurred at <u>5:55</u> AM. from the causes and on the date stated above.							
SIGNATURE <u>William Newman</u>		M.D.		ADDRESS <u>1.22.56</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-24-56</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/23/56</u>		REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>		24. FUNERAL DIRECTOR <u>Howard A. Hubbard</u>		ADDRESS <u>4107 Kiltan Ave</u>	



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00338

349

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Parkville</b>				TOWN <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Oak Haven Nursing Home 9008 Harford Road #14</b>				STREET ADDRESS (If rural give location) <b>3118 Mary Avenue #14</b>			
3. NAME OF DECEASED (Type or Print) <b>Mrs. Frances B. Peshek</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>January 20 19 56</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>	8. DATE OF BIRTH <b>May 10, 1872</b>	9. AGE last birthday <b>83</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mrs. Beatrice Howard, 3118 Mary Avenue</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>CORONARY Arteriosclerosis</b>							
ANTECEDENT CAUSE(S) DUE TO (B) <b>Generalized Arteriosclerosis</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Sept 1953</b> to <b>Jan 20, 1956</b> , that I last saw the deceased alive on <b>Jan 18, 1956</b> , and that death occurred at <b>2:40 p.m.</b> from the causes and on the date stated above.							
SIGNATURE <b>Charles J. Lewis</b> M.D. <b>5701 Belair Rd.</b>				DATE SIGNED <b>1/21/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1/23/56</b>		NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		LOCATION (City, town, or county) <b>Baltimore, Md.</b>	
24. REC'D BY REGISTRAR <b>VS</b>		REGISTRAR'S SIGNATURE <b>Dr. A. M. Bacon</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Harford Road #14</b>		ADDRESS	

S. A. GUTHRIE

NY

17/1/1911

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

208

## CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Arbutus</u>		LENGTH OF STAY (In this place) <u>6 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1206 Greystone Rd.</u>				STREET ADDRESS (If rural give location) <u>1206 Greystone Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Dean</u> (Middle) <u>L.</u> (Last) <u>Pfeifer</u>				(Month) <u>Jan</u> (Day) <u>6</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6/10/1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. #1 St.</u>		11. BIRTHPLACE (State or foreign country) <u>Lincoln Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward M. Kelly</u>				14. MOTHER'S MAIDEN NAME <u>Sophia E. Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>W. Le Roy V. Pfeifer 1206 Rd. Greystone</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Carcinoma Brain</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/1</u> , 19 <u>54</u> , to <u>1/6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/5</u> , 19 <u>56</u> , and that death occurred at <u>6:00</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>John C. H. Galy</u> M.D.				DATE SIGNED <u>1/6/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/9/56</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Logwood Rd.</u>	
24. REC'D BY REGISTRAR <u>Jan. 6, 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. Geo. S. M. Kieffer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan &amp; Son</u>		ADDRESS <u>101st</u>	



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INSTRUCTIONS

**THE ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**THE FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00340

349

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fullerton</u>		Life		TOWN <u>Fullerton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4327 Ridge Road</u>				STREET ADDRESS (If rural give location) <u>4327 Ridge Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Albert</u> (Middle) <u>Pfeiffer</u> (Last) <u>Sr.</u>				(Month) <u>January</u> (Day) <u>13</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>October 19, 1886</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Fireman</u>		<u>Glenn Martin Co.</u>		<u>Baltimore County, Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME <u>David Pfeiffer</u>				14. MOTHER'S MAIDEN NAME <u>Christina Kroll</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-24-7491</u>		17. INFORMANT & ADDRESS <u>Mrs. Albert Pfeiffer-4327 Ridge Road</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>2 hours</u>			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>				<u>many years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 13, 1955</u> to <u>Jan 13, 1956</u> that I last saw the deceased alive on <u>Jan 13, 1956</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>May R. English</u> M.D. <u>5713 Belair Rd</u>				DATE SIGNED <u>Jan 13, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 16, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. H. L. Reifender</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Josephine Funeral Home</u>		ADDRESS <u>7401 Belair Road</u>	





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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00341

350

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> STATE <u>MARYLAND</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> LENGTH OF STAY (in this place) <u>7 Mos.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY _____ CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE CITY</u> STREET ADDRESS (If rural give location) <u>5126 CRAIG AVE.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>GRACE E. PILSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1-4-56</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JULY 10-1883</u>
9. AGE last birthday <u>72</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ABRAHAM PILSON</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH BEANS.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-07-8624</u>	
17. INFORMANT & ADDRESS <u>ROBERT M PILSON 5126 CRAIG AVE.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 120.1 IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerosis with Hypertension</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>and Cardiac Hypertrophy</u>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>1 hour.</u> <u>14 years.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/21/47</u> to <u>1/4/56</u> , that I last saw the deceased alive on <u>1/4/56</u> , and that death occurred at <u>10:25 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. B. Jenkins</u>		DATE SIGNED <u>1/5/56</u>	
ADDRESS (Street, city, town, state) <u>215 E. University Parkway - Balto 15, Md 137</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>1-7-56</u>	NAME OF CEMETERY OR CREMATORY <u>LOUDON PT CEM.</u>	LOCATION (City, town, or county) (State) <u>BALTO MD.</u>
24. REC'D BY REGISTRAR <u>Jan 6, 1956</u>	REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>V. B. Jenkins</u>	ADDRESS <u>4905 York Rd.</u>

ROBERT V. S.

1911

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

00342

Reg. Dist. No. 40

1. PLACE OF DEATH COUNTY <u>Baltimore County</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u> TOWN <u>Glen Arm</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>1</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u> TOWN <u>Glen Arm</u> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Henry E. Plack</u> (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>1/1/56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3/5/71</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>		11. BIRTHPLACE (State or foreign country) <u>Beadenkopf, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Rev. Paul Plack, Montoursville, Pa.</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Disease</u>				19. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>23 hrs.</u> <u>4 yrs</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg, etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 11, 1957</u> to <u>Jan 1, 1956</u> , that I last saw the deceased alive on <u>Dec 31, 1955</u> , and that death occurred at <u>1:30 pm</u> M, from the causes and on the date stated above. SIGNATURE <u>Jefford F. Hudson</u> M.D. ADDRESS <u>Fork, Md.</u> DATE <u>1/2/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>Fork Methodist</u>		LOCATION (City, town, or county) (State) <u>Fork, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>N 3 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. Walter Hammett</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Lock-Blight, Inc.</u>		ADDRESS <u>6009 Hayford Road</u>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 352

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00343  
Reg. Dist.

No. 73

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN Reisterstown Rt. 2</u>				CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWN Reisterstown Rt. 2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Nicodemus Road</u>				STREET ADDRESS (If rural, give location) <u>Nicodemus Road</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>John</u>		(Middle) <u>Nicholas</u>		(Last) <u>Pohlman</u>		(Month) (Day) (Year) <u>Jan. 21 1956</u>	
(Type or Print)							
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 28, 1893</u>	9. AGE last birthday: <u>62</u> yrs.	10. BIRTHPLACE (State or foreign country): <u>Maryland</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Stokers</u>					
13. FATHER'S NAME: <u>John N. Pohlman</u>				14. MOTHER'S MAIDEN NAME: <u>Ida Armola Yingling</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>215-09-3010</u>		17. INFORMANT & ADDRESS: <u>Mrs. John Pohlman, Reisterstown, Md.</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Coronary Occlusion</u>							<u>5 min.</u>
DUE TO							
Antecedent cause(s) (b) <u>Coronary Thrombosis</u>							<u>4 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Angina Pectoris</u>							<u>5 yrs.</u>
DUE TO <u>Arteriosclerotic C-V Disease</u>							<u>6-7 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>none</u>		19b. MAJOR FINDING OF OPERATION: <u>none</u>				20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>none</u>		21c. (City or town) (County) (State) <u>none</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>		21e. INJURY OCCURRED While at <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>D. A. Caples</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-23-56</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Jan. 25, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REG. <u>1-25-56</u>		REGISTRAR'S SIGNATURE <u>Mary J. Eline</u>		24. FUNERAL DIRECTOR ADDRESS <u>Wm. Berryman &amp; Sons, Reisterstown, Md.</u>			

RECEIVED

JAN 25 1956

BUREAU V. B.

353

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE STATE HOSP.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> STREET ADDRESS (If rural, give location) <u>1601 Wilson Pt. Rd. - Balto. 20</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Alice</u> (Middle) <u>B.</u> (Last) <u>Potter</u>	4. DATE OF DEATH (Month) <u>1-10-56</u> (Day) <u>19</u> (Year) <u>19</u>	5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u> 8. DATE OF BIRTH <u>Oct. 1, 1877</u> 9. AGE last birthday <u>78</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland - Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Gearish Gearish</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth ? Benret</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Records of Spring Grove State Hospital</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

## PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

## (CITY OR TOWN)

## (COUNTY)

## (STATE)

## TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☒

## HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

(Doctor or title)

ADDRESS SPRING GROVE STATE HOSP. DATE SIGNED 1-10-56

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

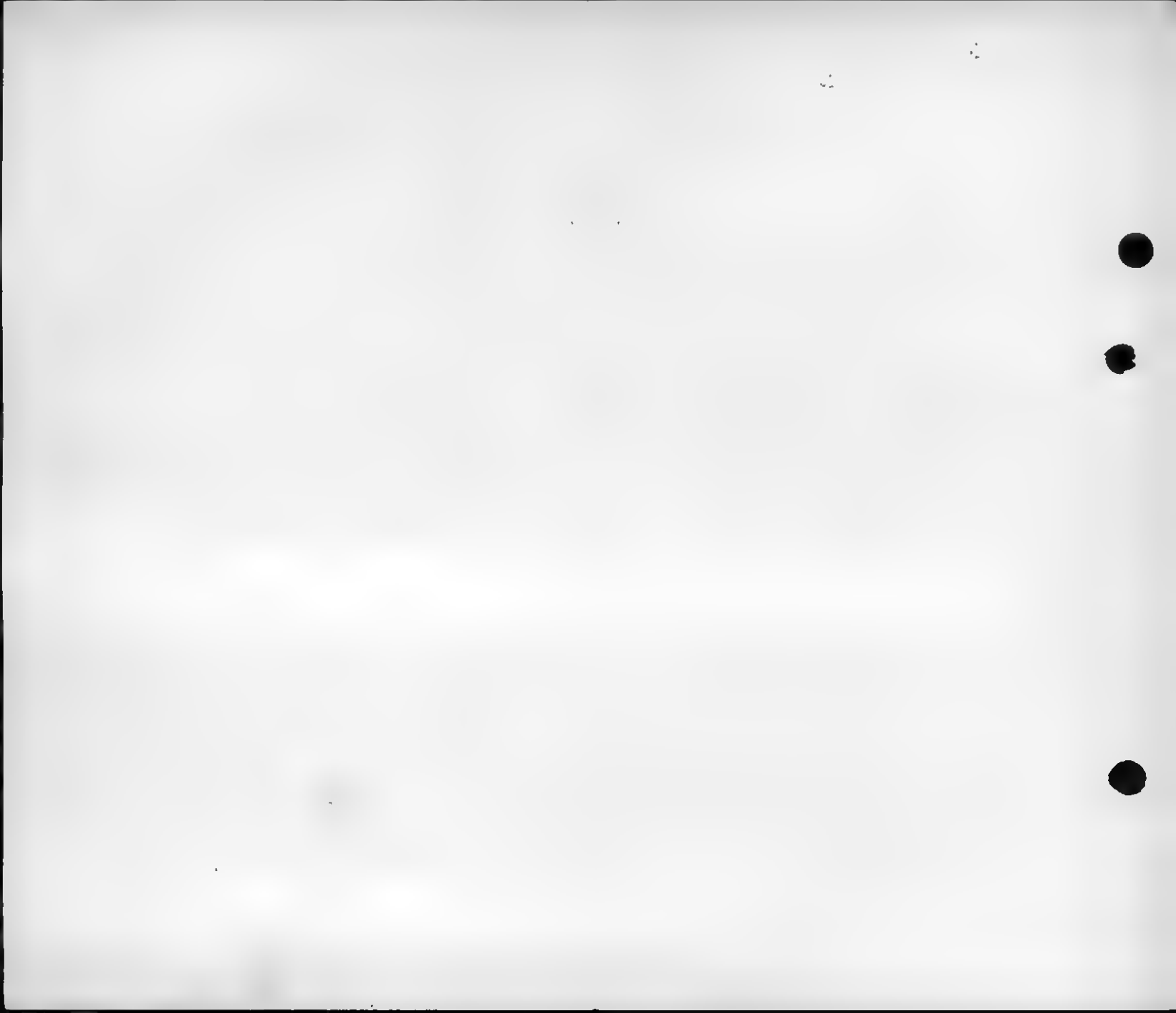
## 24. FUNERAL DIRECTOR

## ADDRESS

Schimunek Funeral Home, Inc.2601-3-5 E. Madison St.

MAICIN RESEVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





354

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u>			STATE <u>Md.</u> COUNTY <u>Balto.</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Edgemere</u>			LENGTH OF STAY (in this place) <u>30yrs</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location) <u>3119 Grace Ave. Road</u> <u>19</u>		
3. NAME OF DECEASED: (First) <u>Benjamin F. Reese</u> (Middle) (Last)			4. DATE OF DEATH: (Month) <u>Jan</u> (Day) <u>2</u> (Year) <u>19 56</u>		
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	
8. DATE OF BIRTH: <u>June 10, 1880</u>		9. AGE last birthday: <u>75</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Machinist</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Beth Steel Co.</u>		
11. BIRTHPLACE (State or foreign country): <u>Pa.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME: <u>Benjamin Reese</u>			14. MOTHER'S MAIDEN NAME: <u>Sarah Wildman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.: <u>213-07-2364</u>		
17. INFORMANT & ADDRESS: <u>Mrs. Minnie Reese, 3119 Garce Rd. 19</u>					

18. MEDICAL CERTIFICATION						Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						
201x Immediate cause (a) <u>Acute Bronchopneumonia</u>						
Antecedent causes (b) <u>Severe anemia and atelectasis</u>						
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Lymphomatous disease. Probably Hodgkin's Disease</u>						
11. OTHER SIGNIFICANT CONDITIONS						
Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>December 28</u> , 19 <u>55</u> , to <u>Jan 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 1</u> , 19 <u>56</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.						
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED
<u>David Owens, M.D.</u>		<u>914 D Street Sparks Rd 19 Md.</u>		<u>1/3/56</u>		
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)
<u>Burial</u>		<u>Jan 5/56</u>		<u>Moreland Mem. Park</u>		<u>Balto. Md.</u>
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS
<u>Jan 3 - 1956</u>		<u>Darwin J. Harbor</u>		<u>Phil's Hewig</u>		<u>2024 Orleans St. 31</u>

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

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JAN 5 1956

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INSTRUCTIONS

209

## CERTIFICATE OF DEATH

00346

Reg. Dist. No. 42

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <u>LANSDOWNE</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1726 HALL AVE.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>BALTIMORE</u> CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <u>LANSDOWNE</u> STREET ADDRESS (if rural give location) <u>1726 HALL AVE</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JOSEPHINE C. REILEY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 23, 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>DEC 15, 1891</u>
9. AGE last birthday <u>64</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>REGAN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS <u>Joseph REILEY 1726 HALL AVE</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arterio-sclerotic heart disease</u>		<u>6 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>renal failure</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1, 1955</u> , to <u>1/23, 1956</u> , that I last saw the deceased alive on <u>1/23, 1956</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Benjamin Miller M.D.</u>		ADDRESS (Street, city, town, state) <u>1426 Light St.</u>	
DATE SIGNED <u>Jan. 24, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. DATE THEREOF <u>1-25-56</u>	
NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS</u>		LOCATION (City, town, or county) (State) <u>A.A. County Md.</u>	
25. REGISTRAR'S SIGNATURE <u>Dr. Geo. S. McElroy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Fleming</u>	
ADDRESS <u>1426 Light St.</u>			

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

1992

355

## CERTIFICATE OF DEATH

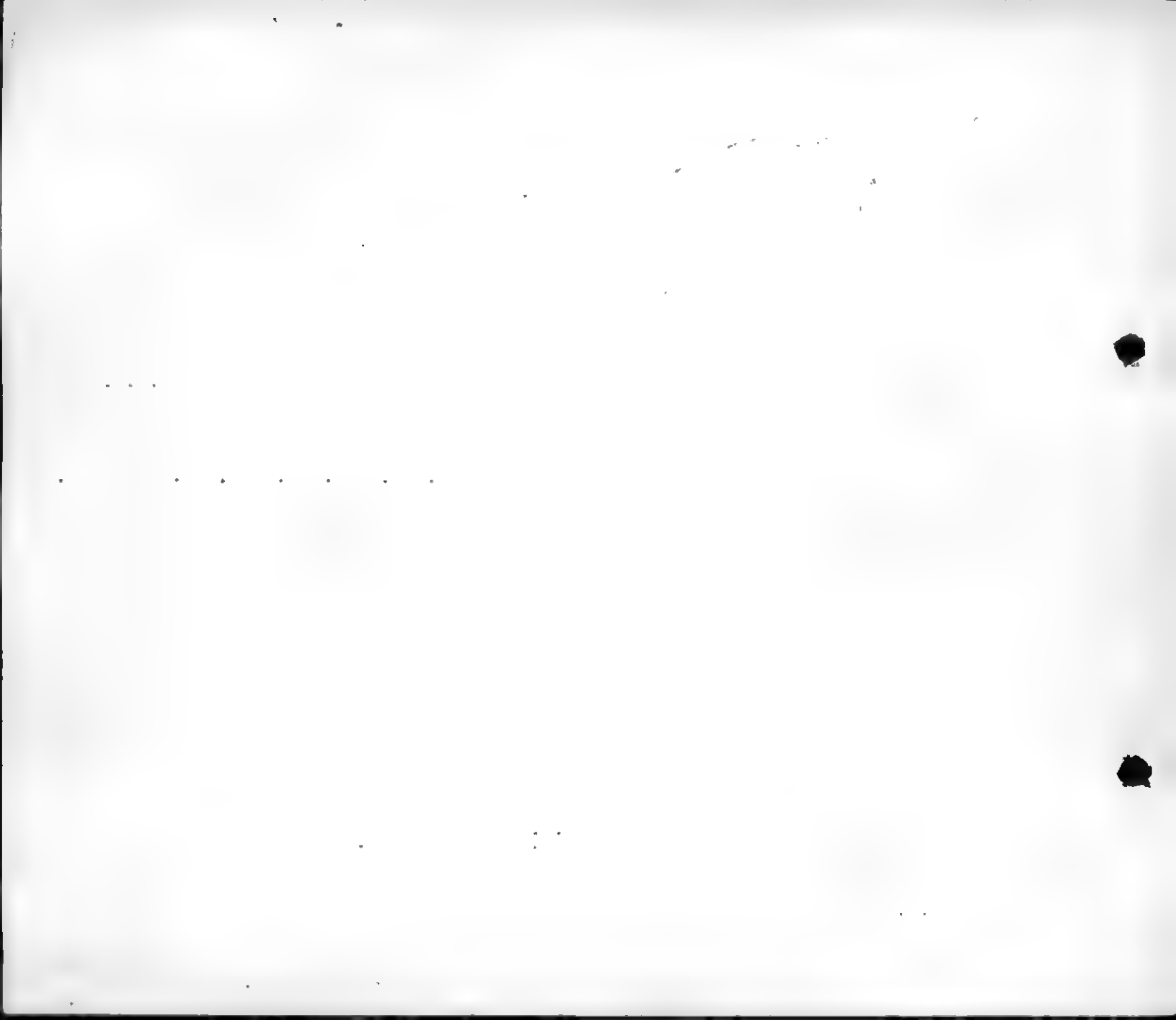
Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>12-1/2 Hrs.</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>740 E. Fort Avenue</u>			
3. NAME OF DECEASED: (First) <u>ANDREW</u>		(Middle) <u>J.</u>		(Last) <u>REILLY</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>January 21, 1956</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>January 3, 1892</u>	9. AGE last birthday: <u>64</u> yrs.	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS.: Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Engineering</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Yes</u> <u>WW-1</u>			16. SOCIAL SECURITY NO. <u>212-01-2689</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
(A) IMMEDIATE CAUSE			(A) <u>CONGESTIVE HEART FAILURE</u>				
(B) ANTECEDENT CAUSE (S)			(B) <u>PULMONARY EMPHYSEMA</u>				UNKNOWN
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>12:00 NN</u>		
22. I hereby certify that I attended the deceased from <u>Jan. 20, 1956</u> , to <u>Jan. 21, 1956</u> , that I attended the deceased and that death occurred at <u>12:00 NN</u> , from the causes and on the date stated above.							
SIGNATURE <u>D.D. Marks</u>			ADDRESS <u>M.D. Fort Howard, Maryland</u>			DATE SIGNED <u>1/21/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-24-56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Maryland</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>1/23/56</u>		REGISTRAR'S SIGNATURE <u>W.W. Hedrick</u>		24. FUNERAL DIRECTOR, ADDRESS <u>Wm. Cook-Blight Inc. Funeral Home 6009 Harford Road, Baltimore 14, Md.</u>			

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



358

## CERTIFICATE OF DEATH

Reg. Dist. No. 46

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>50 days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>3204 Rueckert Ave., Balto 14, Md.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JOHN C RHODES</u>				<u>January 15 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>11/30/92</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Bookkeeper</u>		<u>Bank</u>		<u>Baltimore, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles M. Rhodes</u>				14. MOTHER'S MAIDEN NAME <u>Emma V. Dorsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Yes</u> <u>WWI</u>				<u>Unknown</u>		<u>Clin. Rec. Vets. Admin. Hosp. Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>ADRENAL CORTICAL HYPOFUNCTION</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
<u>Other Significant cond. 1. Arteriosclerotic cardio-vascular disease 2. Rheumatoid arthritis. 3. Pneumonitis, left lung 4. Gastrointestinal hemorrhage.</u>						<u>1. 1 1/2 yrs</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>2. 16 yrs</u>	
19a. DATE OF OPERATION						<u>3. 3 days</u>	
19b. MAJOR FINDINGS OF OPERATION						<u>4. 20. Autopsy</u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>November 26 19 56</u> to <u>January 15 19 56</u> and that death occurred at <u>1:05 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William M. Lavette M.D.</u>				ADDRESS (Street, city, town, state) <u>M.D. Veterans Administration Hosp., Ft. Howard, Md.</u>			
DATE SIGNED <u>1/15/56</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>1-18-56</u>		<u>Baltimore National</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan. 16, 1956</u>		<u>Lawson L. Farley</u>		<u>William Cook, Blight, Inc.</u>		<u>6009 Harford Rd., Balto., Md.</u>	

**INSTRUCTIONS**

**1. TO ATTENDING PHYSICIAN** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2. TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

RECEIVED

JAN 17 1956

BUREAU V.



## CERTIFICATE OF DEATH

Reg. Dist. No. 44

357

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>BALTIMORE</b>		STATE <b>MARYLAND</b>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		LENGTH OF STAY (in this place) <b>7 DAYS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>		STREET ADDRESS <b>1803 WHITMORE AVENUE</b>		(If rural give location)			
3. NAME OF DECEASED (Type or Print) <b>JAMES M. RIGNEY</b>				4. DATE OF DEATH <b>JANUARY 13 19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>		8. DATE OF BIRTH <b>April 19, 1928</b>	
9. AGE last birthday <b>27</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-warehouse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Can company</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>George E. Rigney</b>		14. MOTHER'S MAIDEN NAME <b>Cecelia Clark</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes Korean</b>		16. SOCIAL SECURITY NO. <b>218-22-6627</b>		17. INFORMANT & ADDRESS <b>Clin. Rec., Vet. Adm. Hosp., Fort Howard, Md.</b>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <b>ACUTE LYMPHATIC LEUKEMIA</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 WEEKS</b>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan. 6, 1956</b> , to <b>Jan. 13, 1956</b> , the causes of death were <b>ACUTE LYMPHATIC LEUKEMIA</b> and that death occurred at <b>9:25 PM</b> from the causes and on the date stated above.							
SIGNATURE <b>HOWARD C. KRAMER, M.D.</b>				ADDRESS (Street, city, town, state) <b>VAH, FORT HOWARD, MARYLAND</b>			
DATE <b>1-17-56</b>				DATE SIGNED <b>1/14/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1-17-56</b>		NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. RECEIVED BY REGISTRAR <b>Jan. 16, 1956</b>		REGISTRAR'S SIGNATURE <b>Lawson L. Fisher</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b>		ADDRESS <b>6009 Harford Rd., Balto. Md.</b>	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

JAN 17 1956

RECEIVED

53  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>		<u>1 yr. 4 mth. 21</u> days		TOWN <u>Baltimore City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE STATE HOSP:</u>				STREET ADDRESS (If rural give location) <u>20 N. Calhoun St. - Balto., Md.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)					
<u>Melissa Rigney</u>		<u>Jan. 22, 19 56</u>					
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>female</u>	<u>white</u>	<u>Widowed</u>	<u>Sept. 21 ?</u>	<u>70</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>unknown</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>unknown</u>	
13. FATHER'S NAME: <u>unknown</u>				14. MOTHER'S MAIDEN NAME: <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS:			
<u>unknown</u>				<u>Spring Grove Hospital records</u>			
16. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>							<u>one day</u>
ANTECEDENT CAUSE (B) <u>Diabetes Mellitus</u>							<u>years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized arteriosclerosis</u>							<u>years</u>
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9-4</u> , 1953, to <u>Jan. 22 1956</u> , that I last saw the deceased alive on <u>Jan. 22</u> ... , 1956, and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Melissa Rigney</u>				ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>1-25-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Interment</u>				<u>4/30/56</u>		<u>U. of Md. Med. School</u>	
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>1-25-56</u>				<u>J. E. Darrigo</u>		<u>Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

161-26

BUREAU V. S.

FEB 16 1950

RECEIVED

18 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

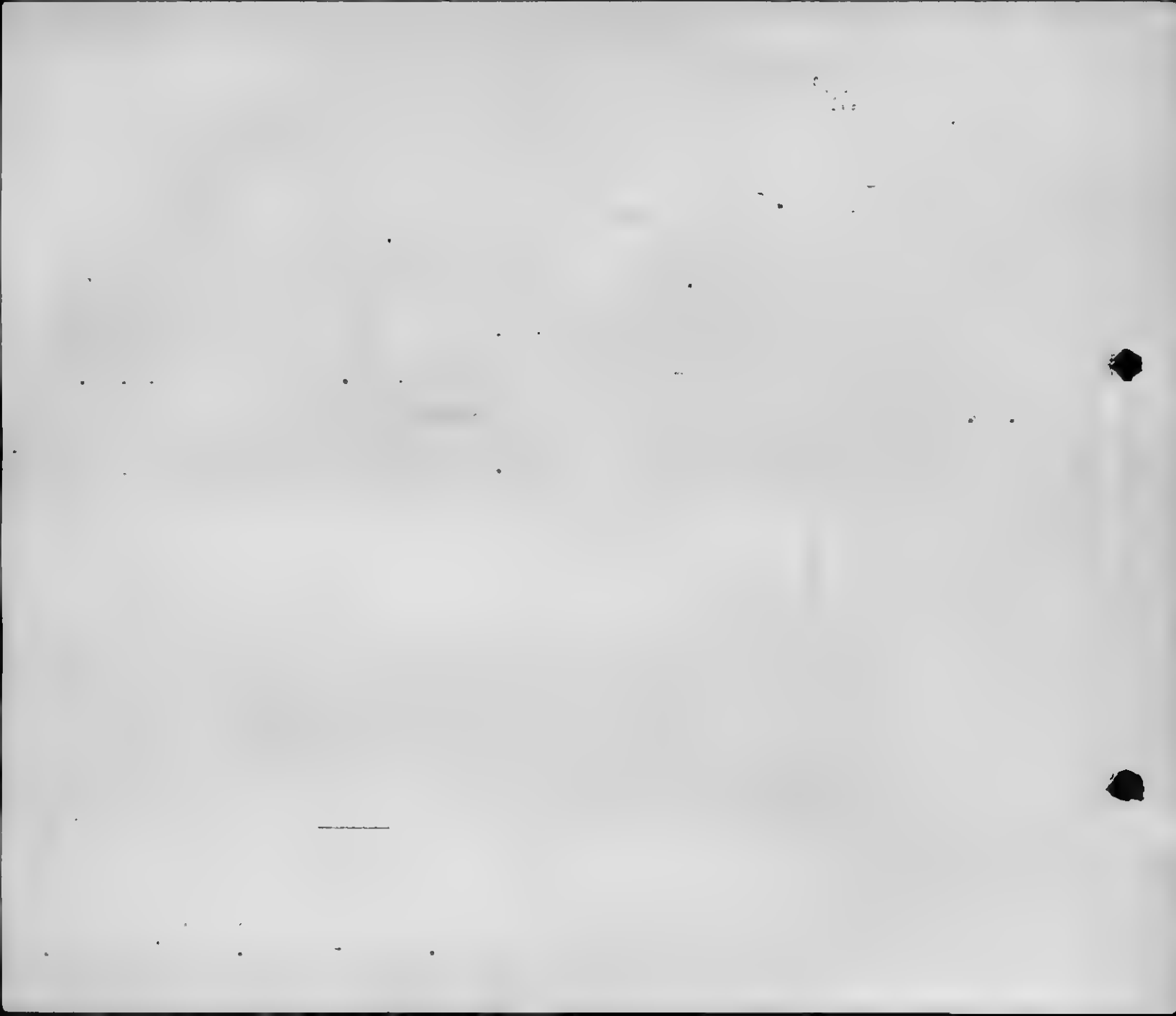
Reg. Dist.

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Baltimore</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Rural Baltimore</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Bethlehem Steel Dispensary</b>				STREET ADDRESS (If rural, give location) <b>605 E. Arlington Avenue</b>			
3. NAME OF DECEASED: (First) <b>Franklin</b> (Middle) <b>W.</b> (Last) <b>Roberts</b>				4. DATE OF DEATH (Month) <b>1</b> (Day) <b>20</b> (Year) <b>1956</b>			
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>		8. DATE OF BIRTH: <b>Sept. 9, 1898</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Shipping Clerk - Steel</b>		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: <b>57</b> yrs.		11. BIRTHPLACE (State or foreign country): <b>Berkley, Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>							
13. FATHER'S NAME: <b>H. P. Roberts</b>				14. MOTHER'S MAIDEN NAME: <b>Annie Nora Pierce</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>Yes</b> (If Yes, give war or dates of service) <b>WW I</b>				16. SOCIAL SECURITY No.: <b>Yes</b>			
17. INFORMANT & ADDRESS: <b>Mrs. Mildred Lee Roberts 605 E. Arlington Ave.</b>							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
<b>+ 21.1</b> <b>Immediate cause (a) DUE TO</b> <b>Calcific Aortic Stenosis, Marked</b> <b>Antecedent cause(s) (b) DUE TO</b> <b>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</b>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <b>Fractured Right Ankle</b>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? <b>Yes</b> <input checked="" type="checkbox"/> <b>No</b> <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>M.</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>Frank P. Moran</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <b>1/20/56</b>			
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>1/23/56</b>		NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		LOCATION (City, town, or county) (State) <b>Frederick, Md.</b>	
DATE REC'D BY LOCAL REG. <b>1/23/56</b>		REGISTRAR'S SIGNATURE <b>G. W. Redman</b>		24. FUNERAL DIRECTOR <b>John A. Moran-3000 E. Baltimore St.</b> ADDRESS			

MARGIN RESERVED FOR FINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**1**

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

360

**CERTIFICATE OF DEATH**

00351

Reg. Dist. No. 37

Mar 2, File 3122 1-31-6 et

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cockeysville</u>		LENGTH OF STAY (In this place) <u>26 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cockeysville Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home of Md.</u>				STREET ADDRESS <u>2610 Dray</u> (If rural give location) <u>3777TH 4104TH RD BALTIMORE MD</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Rachel</u> (First) <u>Rockwell</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>Jan</u> (Day) <u>25</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct. 25 1896</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Lansdown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Cash</u>				14. MOTHER'S MAIDEN NAME <u>Hennetta Finberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Chas Dennis, Masonic Home</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>arteriosclerotic cardiovascular disease</u>			
IMMEDIATE CAUSE (A)				<u>3 years</u>			
ANTECEDENT CAUSE(S) DUE TO				CERTIFICATION APPROVED BY <u>[Signature]</u> M.D.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>fracture left hip</u> CHIEF OR A			
19a. DATE OF OPERATION <u>1/15/56</u>		19b. MAJOR FINDINGS OF OPERATION <u>fractured hip</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street/office bldg, etc.) <u>home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Masonic Home</u> <u>Balto</u> <u>Md</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>1/14/56 2PM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>While working in room, fell to floor</u>			
22. I hereby certify that I attended the deceased from <u>Nov 13, 1953</u> , to <u>Jan 25, 1956</u> , that I last saw the deceased alive on <u>1/24/56</u> , 19 <u>56</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Kees</u>				ADDRESS (Street, city, town, state) <u>Cockeysville Md</u> DATE SIGNED <u>1/24/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>1/27/56</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>	
24. REC'D BY REGISTRAR <u>Jan 26, 1956</u>		REGISTRAR'S SIGNATURE <u>Gene MacRae</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook Jr</u>		LOCATION (City, town, or county) (State) <u>Woodlawn Maryland</u>	

BUTLAND V. S.

AM. 100

W. E. B.



361

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

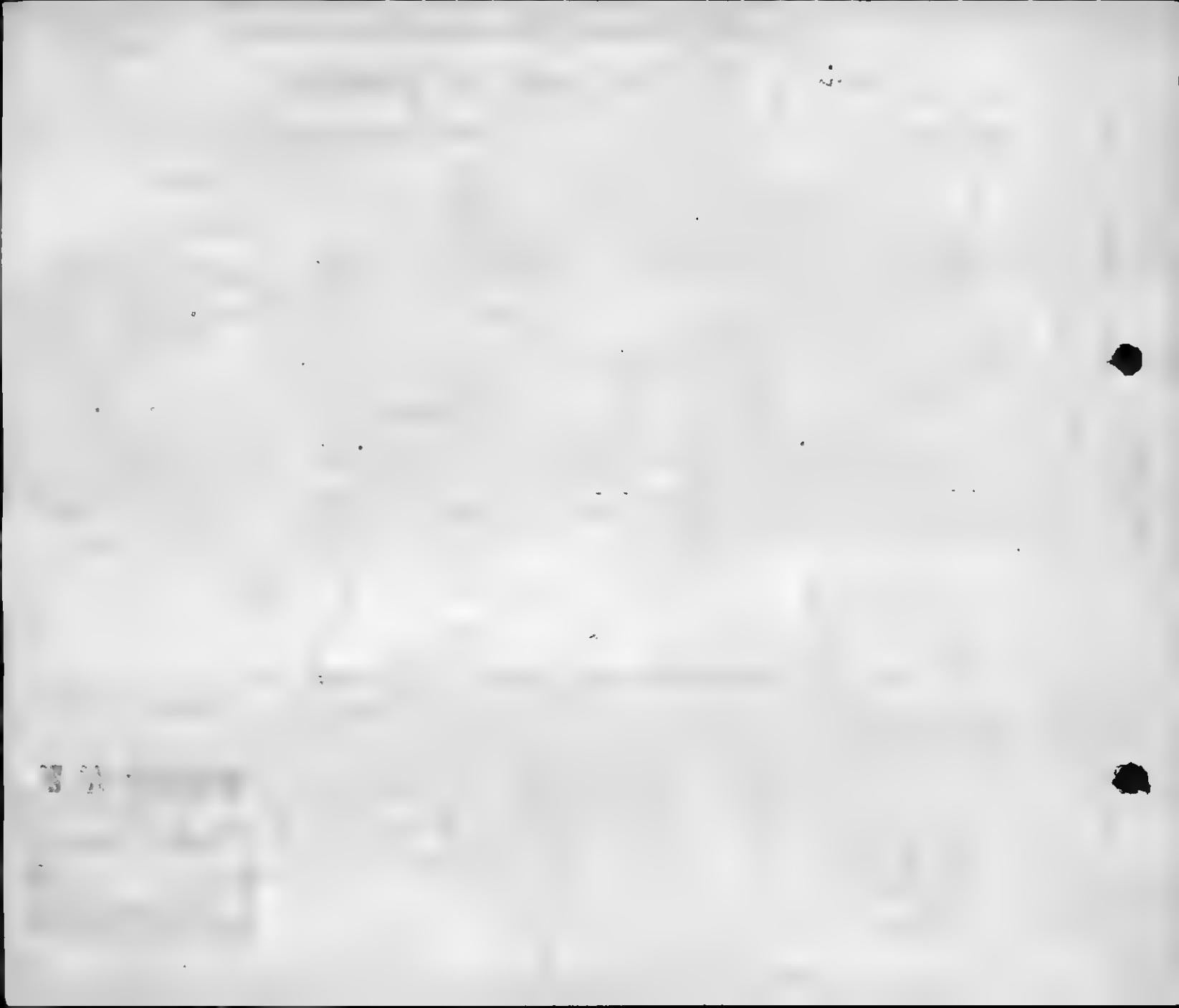
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>				TOWN <u>Baltimore</u>		341	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Daughters of the Eucharist</u>				STREET ADDRESS (If rural give location)			
<u>Recedo Knoll, 601 Maiden Choice Lane</u>				<u>1829 N. Washington Street</u>			
3. NAME OF (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>LULA</u> <u>ROSAZZA</u>				<u>Jan. 3, 1956</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>female</u>		<u>white</u>		<u>single</u>		<u>about 1885</u>	
						<u>about 70 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>never employed</u>						<u>Baltimore, Maryland</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John E. Rosazza</u>				<u>Mary L. ---</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>---</u>				<u>---</u>		<u>Marion A. Figinski, 351 Bldg. Equitable</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>Cranial Occlusion</u>						<u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1913</u> , <u>1953</u> , to <u>1956</u> , that I last saw the deceased alive on <u>12/30</u> , <u>1955</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edith W. Johnson</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
				<u>3432 Rednick Ave</u>		<u>1/5/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>1/7/56</u>		<u>New Cathedral Cemetery</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>1/8/56</u>		<u>F. E. Barry</u>		<u>26m East Ave</u>			
DATE				ADDRESS <u>1217 St. Paul Street</u>			

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

201

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>DUNDALK</u>		<u>2 YRS</u>		TOWN <u>DUNDALK</u>		<u>22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>102 VENTNOR TERRACE</u>				STREET ADDRESS (If rural give location) <u>102 VENTNOR TERRACE</u>			
3. NAME OF DECEASED (Type or Print) <u>MARY HOLTA ROSMUS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1-31-56</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>OCT. 23, 1890</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>65</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAKIA</u>	
13. FATHER'S NAME <u>MICHAEL HOLTA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u> (If Yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME <u>MARY (?)</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS <u>JEAN C. MILLER DUNDALK</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Occlusion</u>				<u>1 hour</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>				<u>2 yrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-28</u> , 19 <u>56</u> , to <u>1-31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-28</u> , 19 <u>56</u> , and that death occurred at <u>10:50</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Jack Challen</u>				ADDRESS (Street, city, town, state) <u>21 Kensington Rd Balt 22</u>			
DATE SIGNED <u>1-31-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-4-56</u>		NAME OF CEMETERY OR CREMATORY <u>LLOYD</u>		LOCATION (City, town, or county) (State) <u>EVANSBURG - PENNA</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>William M. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Bradley</u>		ADDRESS <u>Dundalk, MD</u>	
DATE <u>Feb 2, 1956</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

RECEIVED

SEP 6 1950



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00354

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <b>TOWSON</b> <b>BALTIMORE</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MARYLAND</b> COUNTY <b>BALTIMORE</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON (4)</b> STREET ADDRESS (If rural, give location) <b>602 E. JOPPA ROAD</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>HERMAN</b>	(Middle) <b>LEE</b>	(Last) <b>ROWELL</b>
4. DATE OF DEATH	(Month) <b>JANUARY</b>	(Day) <b>16</b>	(Year) <b>1956</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>AUG 13, 1895</b>
9. AGE last birthday <b>60</b> yrs.	If under 1 year Months Days	If under 24 hrs. Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SAFETY ENGINEER</b>
11. BIRTHPLACE (State or foreign country) <b>GARYSBURG, N.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	13. FATHER'S NAME <b>ALBERT ROWELL</b>	14. MOTHER'S MAIDEN NAME <b>DORA JORDAN</b>
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <b>YES</b>	16. SOCIAL SECURITY NO. <b>241-38-2051</b>	17. INFORMANT AND ADDRESS <b>MRS. ELIZABETH ROWELL, SAME</b>	18. MEDICAL CERTIFICATION
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>MYOCARDIAL INFARCTION</b>			<b>30 MINUTES</b>
Antecedent cause(s) (b) <b>CORONARY OCCLUSION</b>			<b>30 MINUTES</b>
(c) <b>ARTERIOSCLEROTIC CORONARY DISEASE</b>			<b>5 YEARS</b>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <b>SUICIDE</b> <b>HOMICIDE</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>2-28-55</b> to <b>1-16-56</b> , that I last saw the deceased alive on <b>1-14-56</b> , and that death occurred at <b>9:00 A.M.</b> , from the causes and on the date stated above.			
SIGNATURE <b>Arthur K. Rabin M.D.</b>		ADDRESS <b>1532 Havenwood Rd. Baltimore 18</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>	DATE THEREOF <b>JAN. 19, 1956</b>	NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATL. CEM.</b>	LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>
DATE REC'D BY LOCAL REG. <b>JAN. 19, 1956</b>	REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>	24. FUNERAL DIRECTOR <b>John R. Miller, Towson, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. A. 00100

Q51

THIS IS A PERMANENT RECORD.  
PLEASE TYPE OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.  
Every item of information s/c carefully supplied. Physicians: please write the causes of death clearly and let  
THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

263

## CERTIFICATE OF DEATH

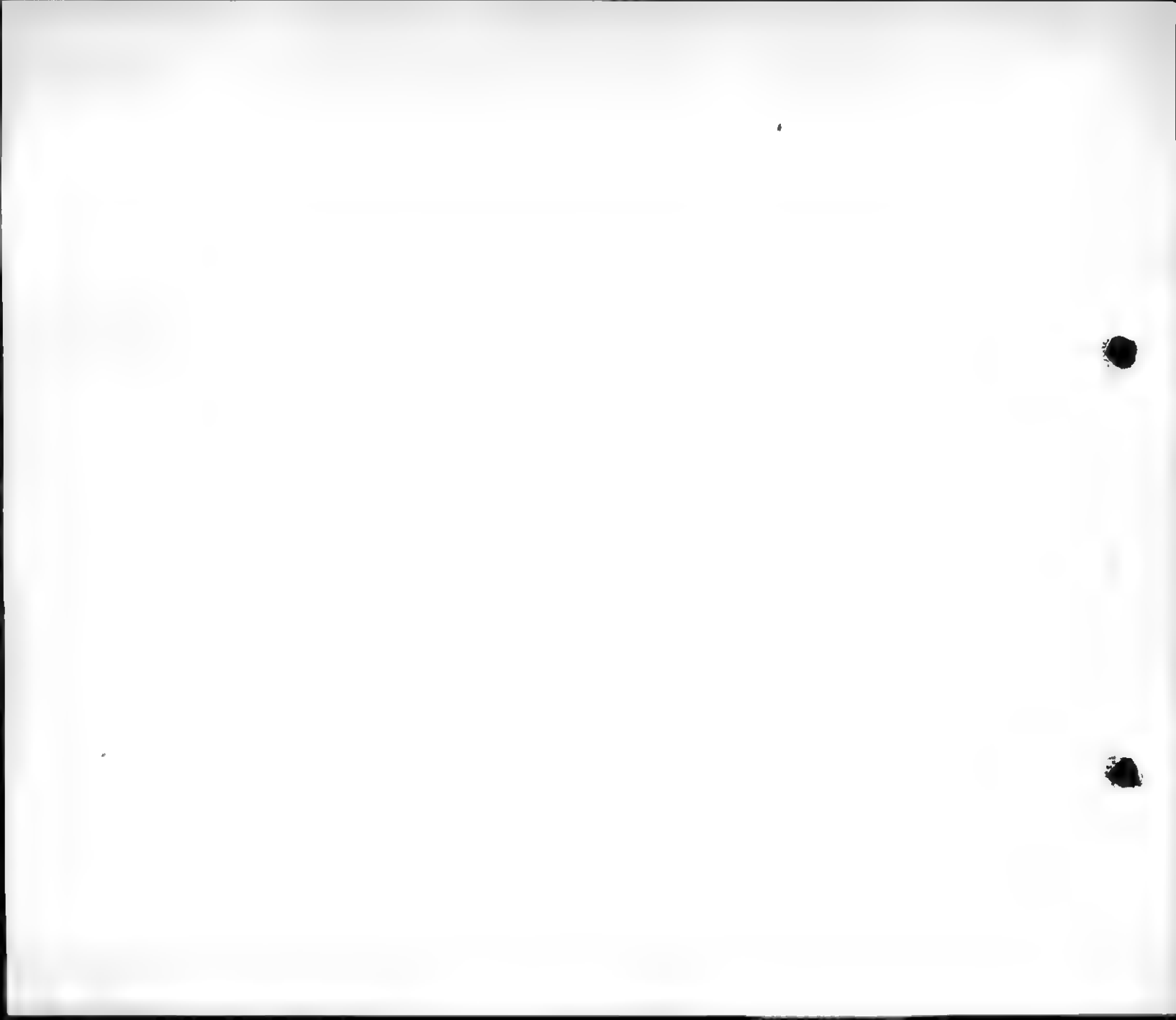
Reg. Dist. No.

00355

1. NAME OF DECEASED (Type or Print)			DELIA A. RUTHERFORD			2. DATE OF DEATH			Jan. 13, 1956		
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore County						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore					
B. FULL NAME OF HOSPITAL OR INSTITUTION Stoneleigh 1010 Overbrook Road						C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Stoneleigh					
c. Length of stay in Baltimore						D. STREET ADDRESS (If rural, give location) 1010 Overbrook Road					
5. SEX female		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH Aug. 11, 1870		9. AGE (In years, last birthday) 85		10. Under 1 Year Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10B. KIND OF BUSINESS OR INDUSTRY at home				11. BIRTHPLACE (State or foreign country) Monroe Co., West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ----- Fisher						14. MOTHER'S MAIDEN NAME -----					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)				16. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS Lillie P. Eads, 1010 Overbrook Rd.					

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  260X ANTECEDENT CAUSES		24 hours	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  260X DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		15 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  Septic - Anterior		10 yrs	

19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? *YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 13 - 1956 that (I) (we) last saw the deceased alive on Jan. 11 - 1956 and that death occurred at 6:15 A. m., from the causes and on the date stated above.					
23A. SIGNATURE A. H. HARRISON		23B. ADDRESS 1710 E. 33 St		23C. DATE SIGNED 1-13-56	
24A. BURIAL, CREMATION, REMOVAL (Specify) removal		24B. DATE 1/13/56		24C. NAME OF CEMETERY OR CREMATORY Wildwood Cemetery	
24D. LOCATION (City, town, or county) (State) Beckley, West Virginia		24E. FUNERAL DIRECTOR New People Inc.		24F. ADDRESS 1217 St. Paul Street	





**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-25 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

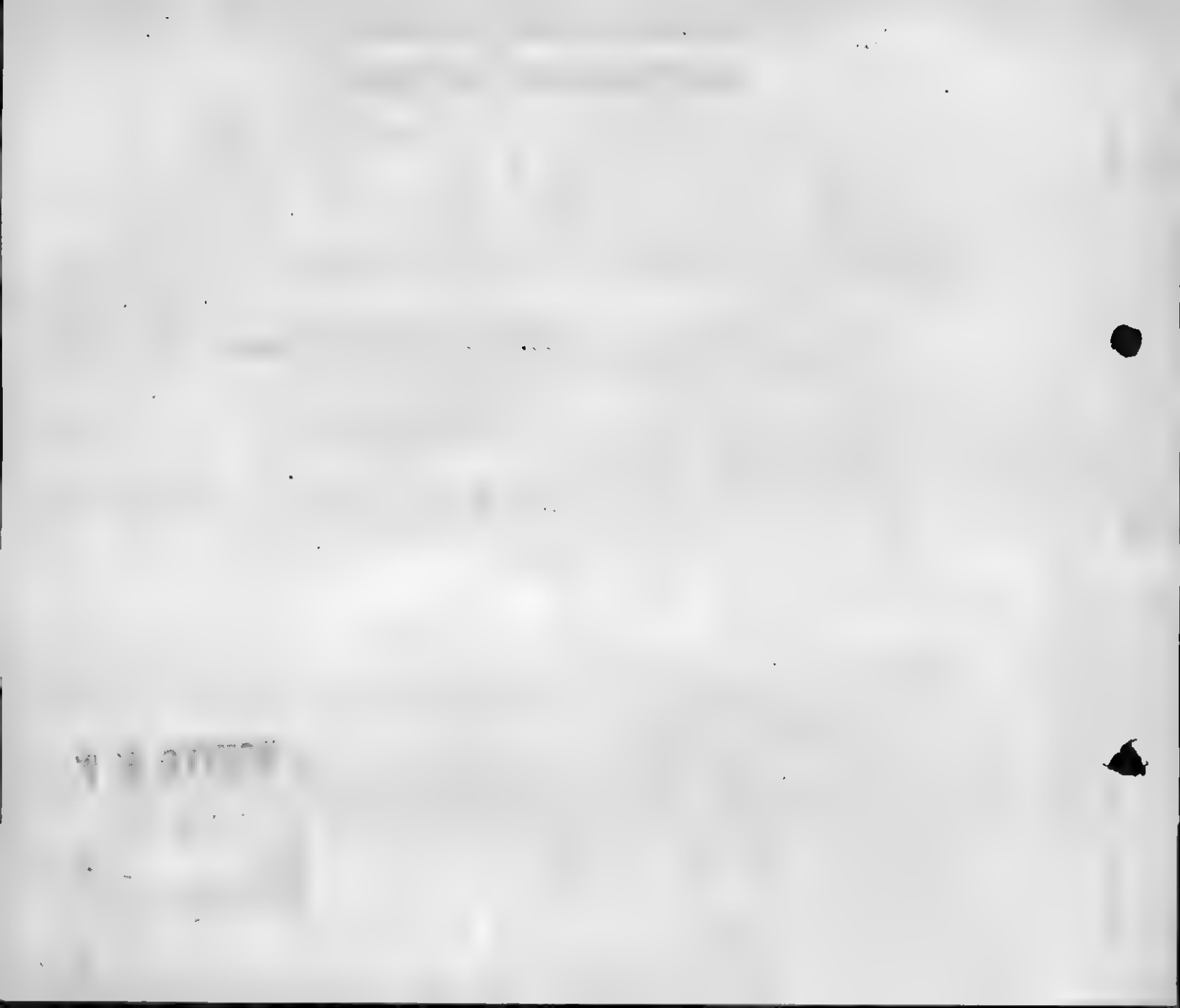
00356

364

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore County</u>		STATE <u>MARYLAND</u>		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Riderwood</u>		<u>16 days</u>		TOWN <u>Baltimore, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7915 Ruxway Road</u>				STREET ADDRESS (If rural give location) <u>2810 North Calvert Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Lillian Schaeffer</u>				<u>Jan 4th, 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Oct. 15, 1897</u>	<u>58</u> yrs.	Months Days	Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>unknown</u>		<u>unknown</u>		<u>unknown</u>			
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
				<u>unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
		<u>unknown</u>					
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>441X</u> IMMEDIATE CAUSE (A) <u>acute embolism from pulmonary artery</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>hypertension arteriosclerotic</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>fracture right forearm, open</u>				I month			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<u>hepatitis chronic</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>CERTIFICATION APPROVED</b>			
<u>Dec 15, 1955</u>		<u>fracture of right arm</u>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<input type="checkbox"/>		<u>home</u>		<u>home</u>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>		<b>CHIEF OR ASST. MEDICAL EXAMINER.</b>	
<u>unknown Dec 15, 1955</u>		<input type="checkbox"/> <input checked="" type="checkbox"/>		<u>accident fall at home</u>			
<b>22. I hereby certify that I attended the deceased from <u>Dec 15, 1955</u> to <u>Jan 4, 1956</u>, that I last saw the deceased alive on <u>Dec 15, 1955</u>, and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>Anna Graham Martin</u> M.D.				<u>Jan 4, 1956</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>burial</u>		<u>1/9/56</u>		<u>Druid Ridge Cemetery</u>		<u>Pikesville, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>DATE</u>		<u>Nobel Gray</u>		<u>Wm. Cook, Inc.</u>		<u>1217 St. Paul St.</u>	



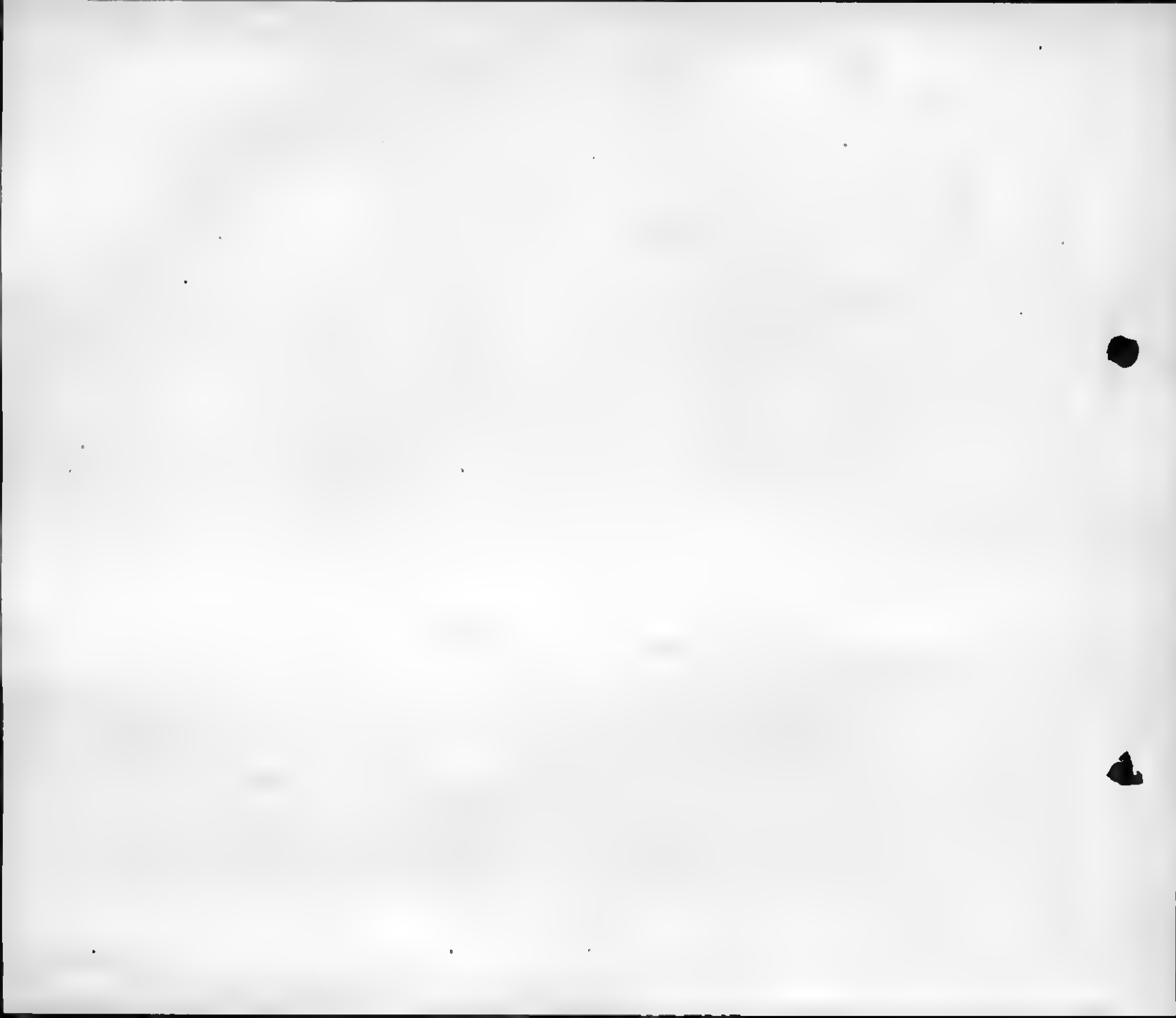
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1800357

## 365 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>New York</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Ruxton</u>				TOWN <u>Freeport, Long Island</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Soransen Nursing Home</u>				STREET ADDRESS (If rural give location) <u>11 Leonard Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>ELIZABETH SCHAFFER</u>				<u>Jan. 3, 1956</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):		8. DATE OF BIRTH:	
<u>female</u>		<u>white</u>		<u>widowed</u>		<u>July 2, 1875</u>	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>80 yrs</u>		<u>retired housewife</u>				<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Freeland</u>				<u>Wilhelmina</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>no</u>		<u>Glyndon, Md.</u> <u>Mrs. Mary C. Gambrill - 128 Butler Rd., /</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						5 days	
IMMEDIATE CAUSE (A) <u>Uremic coma</u>						DUE TO	
ANTECEDENT CAUSE (S) (B) <u>Nephritis - chronic interstitial</u>						DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis - general</u>						DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus</u>						2 weeks	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-1-55</u> , to <u>1-3-56</u> , that I last saw the deceased alive on <u>1-2-56</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Samuel H. Saffell</u>		M. D. <u>Freeport, Md.</u>		DATE SIGNED <u>1-3-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/5/56</u>		<u>St. Paul's Cem.</u>		<u>Prince Frederick, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
		<u>W. H. ...</u>		<u>Wm. J. ...</u>		<u>17, ...</u>	



366

## CERTIFICATE OF DEATH

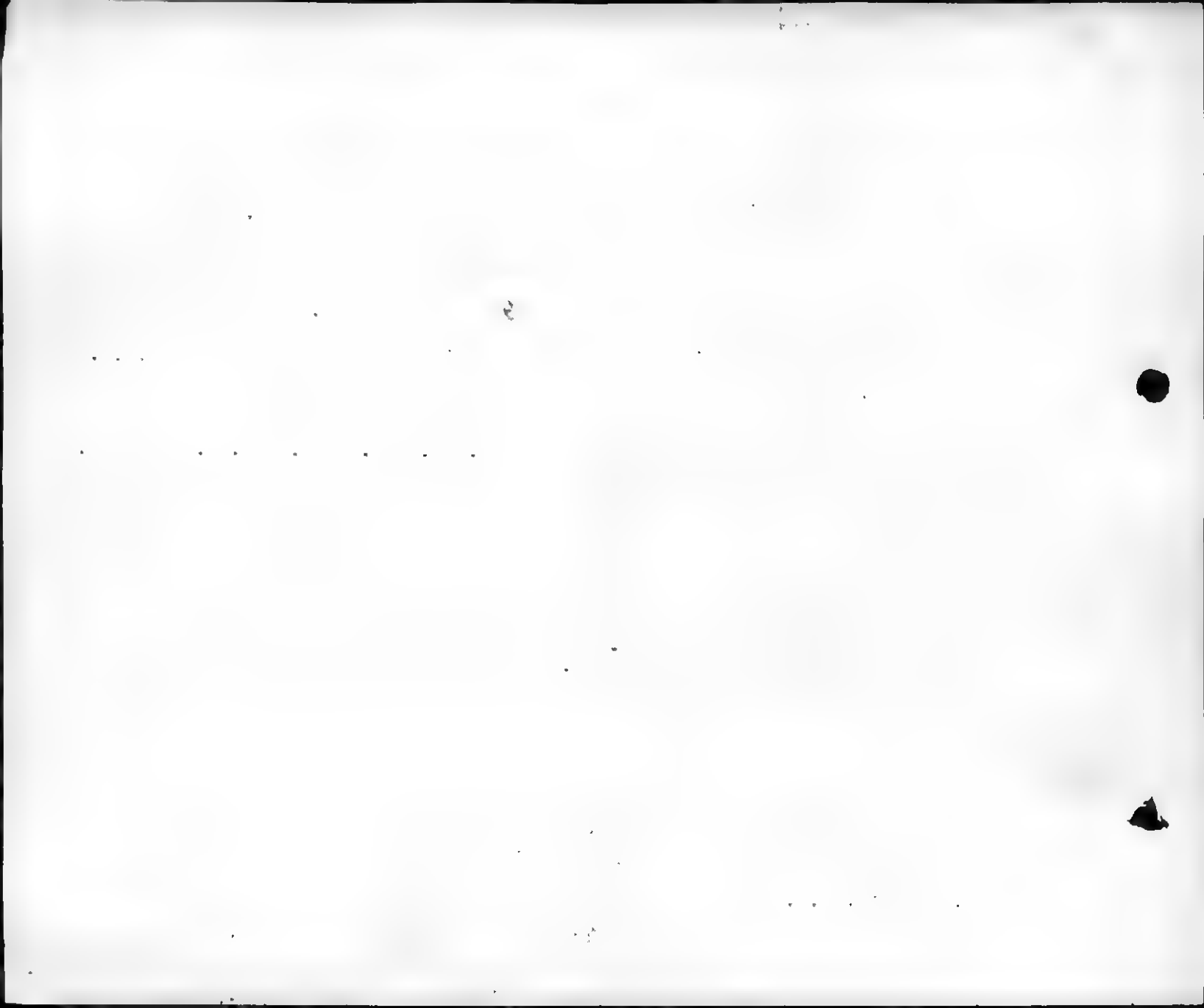
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>52 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1905 Linden Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>HARRY</u> (NMI) <u>SCHAPIRO</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>January 16 19 56</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>12/22/94</u>	9. AGE last birthday: <u>61</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	11. IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Social Security</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Soleman Schapiro</u>				14. MOTHER'S MAIDEN NAME: <u>Ida (Unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk) (If Yes, give year or dates of service) <u>WWI</u>			16. SOCIAL SECURITY No. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vets. Admin. Hosp. Ft. Howard, Md.</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE</u>							UNKNOWN
ANTECEDENT CAUSE (B) <u>GENERALIZED ARTERIOSCLEROSIS</u>							UNKNOWN
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>1. Arteriosclerotic cardio-vascular disease 2. Myocardial infarction</u>							UNKNOWN
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>November 25 19 55</u> , to <u>January 16 19 56</u> , and that death occurred at <u>5:00 P M</u> , from the causes and on the date stated above.							
SIGNATURE <u>John J. Kennedy</u>				ADDRESS <u>M.D. VAH Fort Howard, Maryland</u>		DATE SIGNED <u>1/16/56</u>	
23. BURIAL. CREMATION. REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 17 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Bnai Israel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON &amp; BROTHERS 1126 W North Ave. Baltimore, Maryland Sol Levinson - Pres. Inc.</u>			

MARGIN RESERVED FOR BINNING

VS. A15 —

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

100859

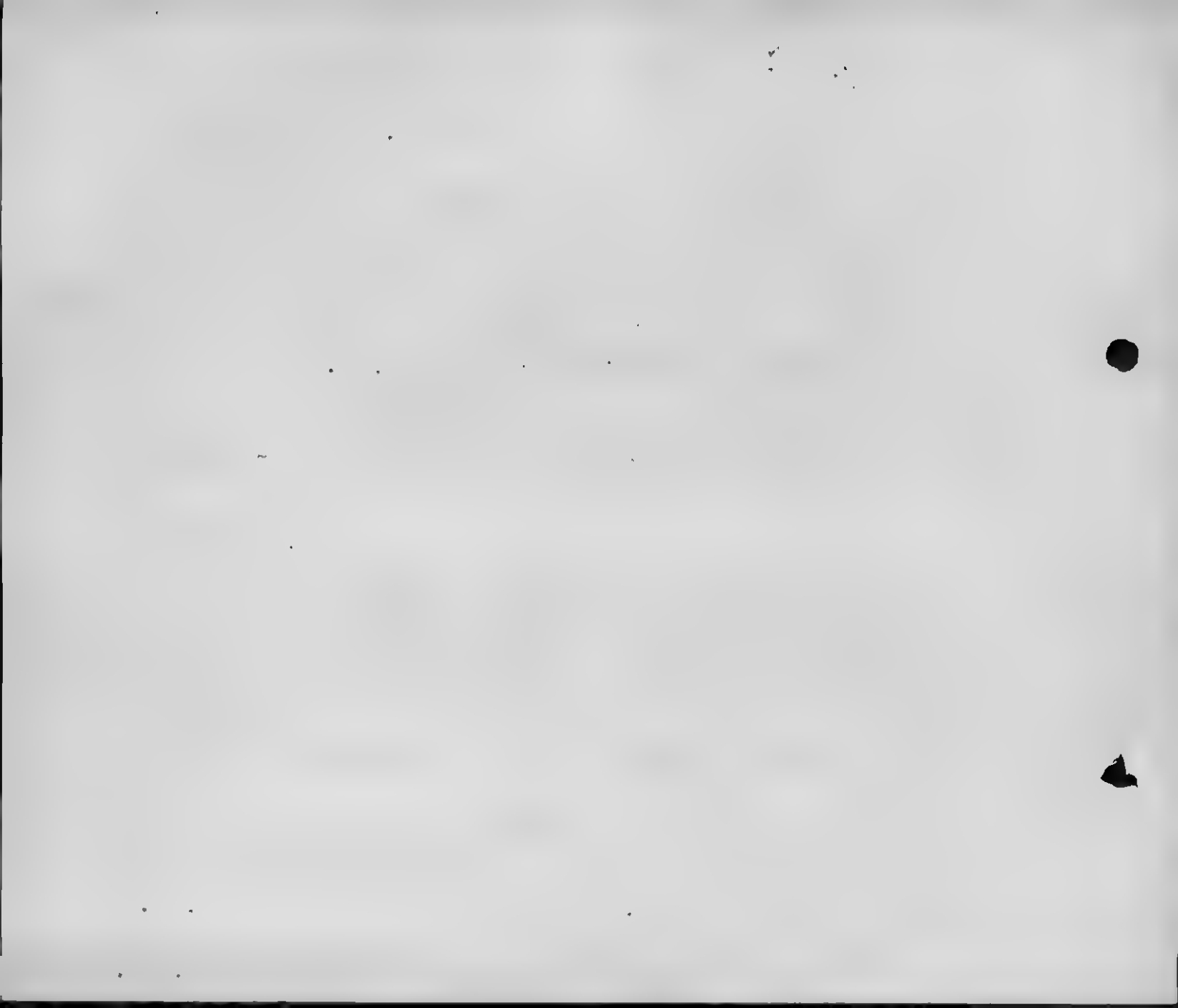
No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Randallstown</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Randallstown</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Old Court Road</b>				STREET ADDRESS (If rural, give location) <b>Old Court Road</b>			
3. NAME OF DECEASED: (Type or Print) <b>IRVIN, F. M. L. R. SCHISLER</b>				4. DATE OF DEATH <b>JAN 3 1952</b>			
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>		8. DATE OF BIRTH: <b>July 12, 1886</b>	
9. AGE last birthday: <b>69</b> yrs.		10. BIRTHPLACE (State or foreign country): <b>Hebbville, Md.</b>		11. CITIZEN OF WHAT COUNTRY?			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Yeast maker</b>				10b. KIND OF BUSINESS OR INDUSTRY: <b>Calvert Distillers</b>			
13. FATHER'S NAME: <b>Louis Schisler</b>				14. MOTHER'S MAIDEN NAME: <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>216-03-8441</b>		17. INFORMANT & ADDRESS: <b>Katie Snyder Schisler - Old Court Road</b>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <b>Asphyxiation by hanging &amp; second +</b>				DUE TO <b>3rd degree burn</b>				<b>10 min</b>	
Antecedent cause(s) (b) <b>Set himself on fire &amp; stepped off of trap ladder to a wire around</b>				DUE TO <b>this neck - suicide</b>				<b>10 min</b>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <b>True to description</b>								<b>10 min</b>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.									
19a. DATE OF OPERATION: <b>7:15 PM</b>				19b. MAJOR FINDING OF OPERATION: <b>2nd degree</b>				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <b>Home</b>		21c. (City or town) (County) (State): <b>Randallstown Balt. Md.</b>					
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <b>Jan 3 1952 2:45 PM</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Hung himself &amp; set himself on fire</b>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
SIGNATURE <b>D. D. Caple</b>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <b>1-3-52</b>			
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF: <b>1/6/1956</b>		NAME OF CEMETERY OR CREMATORY: <b>Mt. Olive Cemetery</b>		LOCATION (City, town, or county) (State): <b>Randallstown, Md.</b>			
DATE REC'D BY LOCAL REG. <b>1/6/56</b>		REGISTRAR'S SIGNATURE <b>W. P. D. Caple</b>		24. FUNERAL DIRECTOR <b>Ellsworth Armacost</b>		ADDRESS <b>Ellsworth Armacost - 4600 Liberty Hgts. Ave. 7</b>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

368

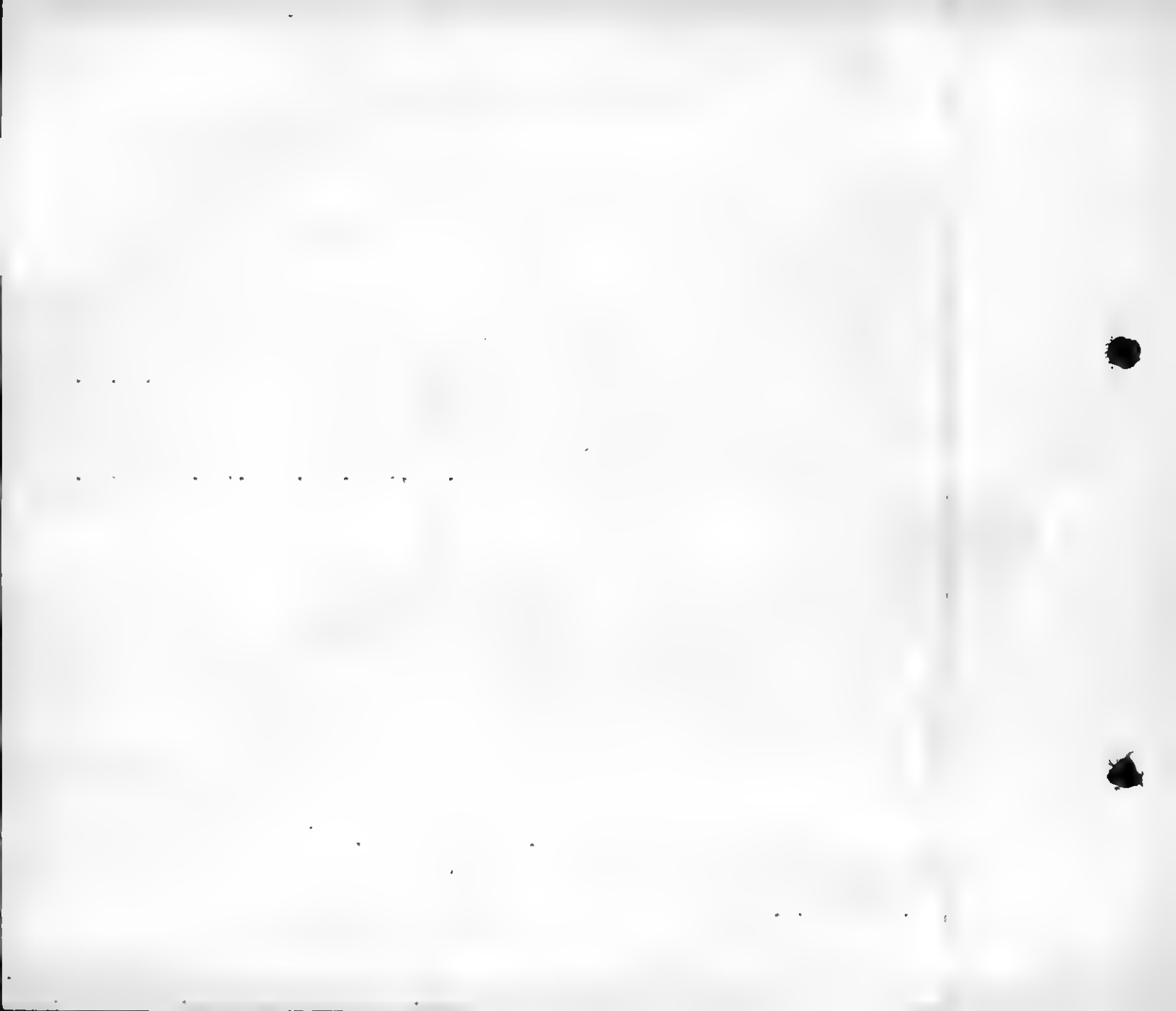
## CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>MARYLAND</b>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWN FORT HOWARD</b>	LENGTH OF STAY (in this place) <b>5 HOURS</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWN BALTIMORE</b>	<b>52</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>		STREET ADDRESS (If rural give location) <b>112 OSBORNE AVENUE</b>	
3. NAME OF DECEASED: (Type or Print) <b>CHARLES O. SCHOBURG</b>		4. DATE (Month) (Day) (Year) OF DEATH <b>JANUARY 22 1956</b>	
5. SEX: <b>MALE</b>	6. COLOR OR RACE: <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>SINGLE</b>	8. DATE OF BIRTH: <b>APRIL 23, 1914</b>
9. AGE last birthday: <b>41</b> yrs.		10. MONTHS: <b>1</b>	11. DAYS: <b>1</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Cigar Counter</b>	11. BIRTHPLACE (State or foreign country): <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME: <b>Herman Schoburg</b>	
14. MOTHER'S MAIDEN NAME: <b>Rose Gardner</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>Yes PTE</b>	
16. SOCIAL SECURITY No. <b>218-03-3128</b>		17. INFORMANT & ADDRESS: <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <b>RHEUMATIC ENDOCARDITIS WITH MITRAL STENOSIS</b>		UNKNOWN	
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>ACUTE PULMONARY EDEMA</b>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 22, 1956, to Jan. 22, 1956, and that death occurred at 9:45 PM, from the causes and on the date stated above.			
SIGNATURE <b>Donald D. Mark, M.D.</b>		ADDRESS <b>M. D. VAH, FORT HOWARD, MARYLAND</b>	
DATE SIGNED <b>1/23/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Jan 26, 1956</b>	
NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
OATE REC'D BY LOCAL REGISTRAR <b>1/24/56</b>		REGISTRAR'S SIGNATURE <b>awd-duch/tib</b>	
24. FUNERAL DIRECTOR <b>Henry W. Mears &amp; Sons</b>		ADDRESS <b>Balto. Md. 805 N. Calvert St.</b>	

MARGIN RESERVED FOR BINDING



269

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

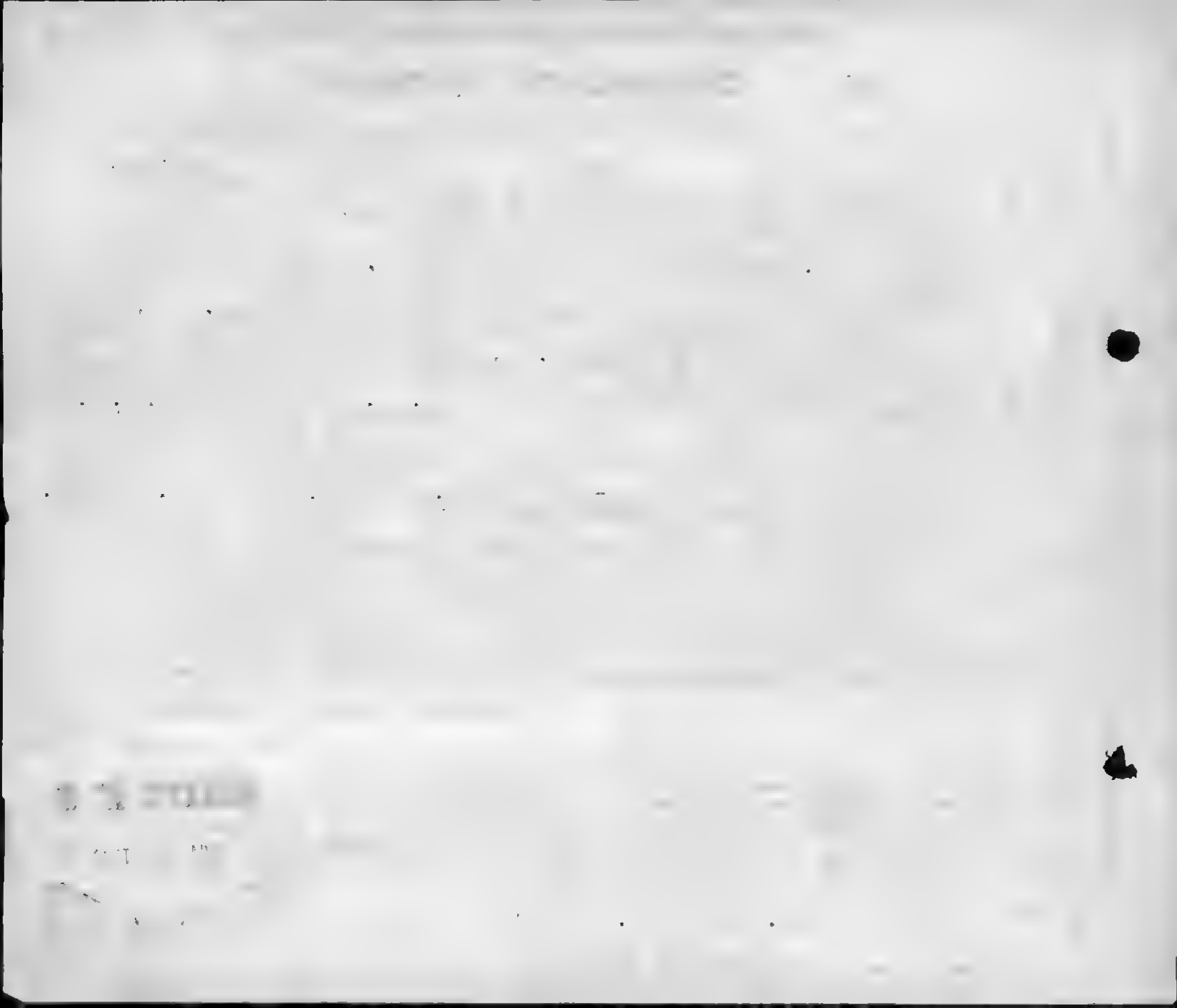
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY OR TOWN <u>Perry Hall</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Perry Hall</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>E. Joppa Road</u>				STREET ADDRESS <u>E. Joppa Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Fred Frederick Christian Schwartz</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 23, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 29, 1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Florist</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Herman Schwartz</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Dietz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-32-0978</u>		17. INFORMANT & ADDRESS <u>Mrs. Pauline M. Schwartz E. Joppa Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Artery Disease (Thrombosis)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 30, 1956</u> , to <u>Jan 23, 1956</u> , that I last saw the deceased alive on <u>Jan 14, 1956</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. J. Standing</u>		M. D. <u>3805 Belair Rd Baltimore, Md</u>		DATE SIGNED <u>Jan 24/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 26, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michael's Lutheran</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 27, 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. Walter Bennett</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Larsen Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00362

370

## CERTIFICATE OF DEATH

Reg. Dist. No. ..

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>37 Days</u>		TOWN <u>Baltimore (Arbutus)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1106 Sulphur Spring Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>VERNON SCOTT</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 6 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>August 8, 1894</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Box Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Halethorpe, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Scott</u>				14. MOTHER'S MAIDEN NAME <u>Hannah MN: Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If Yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.</u>			
15. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						1 YEAR	
IMMEDIATE CAUSE (A) <u>CARCINOMA OF THE LEFT ORBIT WITH METASTASIS</u>							
ANTECEDENT CAUSE(S) <u>TO LUNGS AND LIVER</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 30</u> , 19 <u>55</u> , to <u>Jan. 6</u> , 19 <u>56</u> , and that death occurred at <u>1:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Donald D. Mark, M.D.</u>				ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>1-6-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 9, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Western Star Cem.</u>		LOCATION (City, town, or county) (State) <u>Catonsville Md.</u>	
24. RECEIVED BY REGISTRAR <u>JAN 9 1956</u>		REGISTRAR'S SIGNATURE <u>Dawson L. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Katie R. Williams</u>		ADDRESS <u>322 N. Schroeder St. Baltimore</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



371  
CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 20</u>		LENGTH OF STAY (in this place) <u>since 16 1453</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 23</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hospital</u>				STREET ADDRESS (If rural give location) <u>2318, Frederick Ave</u> ✓			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>CAROLINE K SEIPPEL</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>10-21 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>W</u>	8. DATE OF BIRTH: <u>10.17.1859</u>	9. AGE last birthday <u>96</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry Ott</u>				14. MOTHER'S MAIDEN NAME: <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Henry K. Seippel-7518 Frederick Ave</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A) <u>Bilateral pleural effusions</u>					
ANTECEDENT CAUSE (B)		DUE TO (B) <u>Decompensatory heart disease</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO (C) <u>Arteriosclerotic cardiovascular disease</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12.16</u> , 19 <u>53</u> , to <u>1.21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1.21</u> , 19 <u>56</u> , and that death occurred at <u>1.30</u> P M, from the causes and on the date stated above.							
SIGNATURE <u>Rena Becker</u>		M. D. <u>Spring Grove Hospital</u>		DATE SIGNED <u>1/21/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 25/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rowdown Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/24/56</u>		REGISTRAR'S SIGNATURE <u>T.E. Harry</u>		FUNERAL DIRECTOR <u>A.B. Whippert</u>		ADDRESS <u>300 E. 1st St. Pl.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

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RECEIVED



372

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>Md.</u>		COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		LENGTH OF STAY (In this place) <u>8 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
TOWN				STREET ADDRESS (If rural give location) <u>504 FOREST LANE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>504 FOREST LANE</u>				STREET ADDRESS <u>504 FOREST LANE</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Anne</u> (Middle) <u>ELAINE</u> (Last) <u>SMITH</u>				(Month) <u>JAN.</u> (Day) <u>24</u> (Year) <u>1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 22, 1924</u>	9. AGE last birthday <u>31</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if (Specify) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDGAR HILDITCH</u>				14. MOTHER'S MAIDEN NAME <u>MARY L. LYNN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-12-7876</u>		17. INFORMANT & ADDRESS <u>EARL SMITH 504 FOREST LANE</u>			
(If Yes, give war or dates of service) <u>NONE</u>							
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						19. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Sepsis Myeloid</u>						INTERVAL BETWEEN ONSET AND DEATH <u>13 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/4</u> ....., 19 <u>46</u> ....., to <u>1/24</u> ....., 19 <u>56</u> ....., that I last saw the deceased alive on <u>1/23</u> ....., 19 <u>56</u> ....., and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Eliot W. Johnson M.D.</u>				ADDRESS (Street, city, town, state) <u>3432 Madison Ave. Baltimore Md 21208</u>			
DATE <u>Jan. 26, 1956</u>				DATE SIGNED <u>1/24/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>1-27-56</u>		NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>	
24. REG'D BY REGISTRAR <u>Jan. 26, 1956</u>		REGISTRAR'S SIGNATURE <u>T. E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schaub</u>		ADDRESS <u>2101 Federal Ave.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

STANDARD A. S.

1000

1000

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information — carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00365

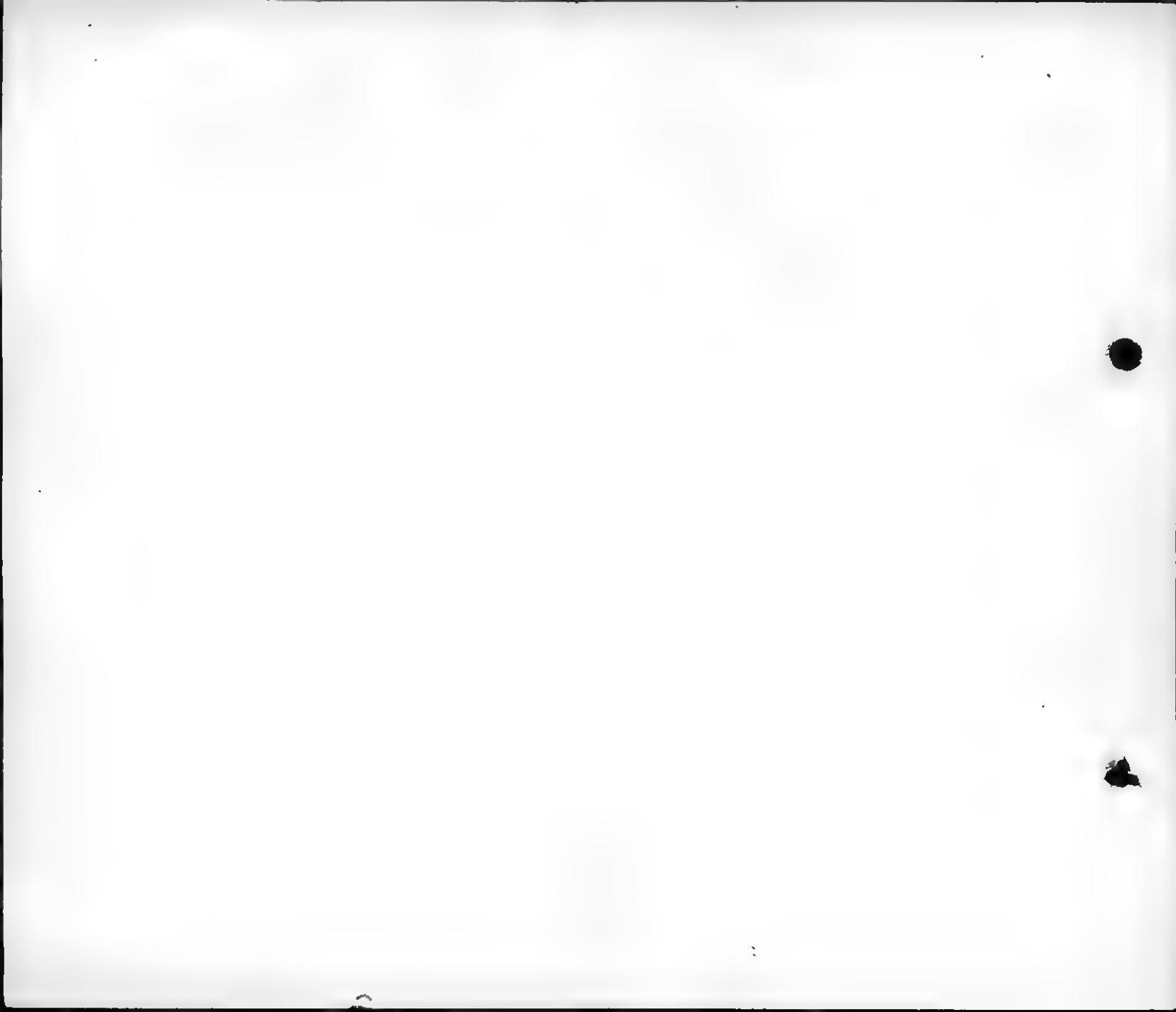
373

## CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		LENGTH OF STAY in this place <u>2 yrs 18 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hosp.</u>				STREET ADDRESS (If rural give location) <u>420 W. Franklin St.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Ella (ELLEN) Starr Smith</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1-3-1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>6/8/1879</u>	9. AGE last birthday <u>76 yrs.</u>	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Unknown</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Ireland</u>	
12. CITIZEN OF WHAT COUNTRY: <u>Ireland</u>							
13. FATHER'S NAME: <u>Peter Starr</u>				14. MOTHER'S MAIDEN NAME: <u>Mary McQuade</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT'S ADDRESS: <u>Brook Spring Grove State Hosp.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>							
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Coronary thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-1-1953</u> to <u>1-3-1956</u> that I last saw the deceased alive on <u>1-3-1956</u> , and that death occurred at <u>10:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Sheila Wachler</u>		M.D. <u>Spring Grove State Hosp.</u>		DATE SIGNED <u>1/3/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM.</u>		LOCATION (City, town, or county) (State) <u>4300 OLD FREDERICK RD BALTO, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-16</u>		REGISTRAR'S SIGNATURE <u>Howell</u>		24. FUNERAL DIRECTOR <u>Charles S. Guler</u>		ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>	



**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate **must** be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00366

374

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>BALTIMORE</b>		STATE <b>MARYLAND</b>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>FORT HOWARD</b>		LENGTH OF STAY (in this place) <b>70 Days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>ELKRIDGE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>1711 Levering Avenue</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>JOSEPH SMITH</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>January 6, 1956</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>MARRIED</b>	<b>8. DATE OF BIRTH</b> <b>June 24, 1893</b>		<b>9. AGE last birthday</b> <b>62 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Car Company</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13. FATHER'S NAME</b> <b>Jim Smith</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>YES</b> <b>WW-1</b>			<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Clin. Rec., Vet. Adm. Hosp. Fort Howard, Md.</b>		
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <b>LYMPHATIC LEUKEMIA</b>						INTERVAL BETWEEN ONSET AND DEATH <b>16 Mos.</b>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>12-2-55</b>			<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>CLOSED THORACOTOMY, DRAINAGE</b>			<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>			<b>21b. PLACE</b> (Home, farm, factory, of injury street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)			<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>		
<b>22. I hereby certify that</b> <b>VA</b> <b>attended the deceased from</b> <b>10-28-55</b> <b>to</b> <b>1-6-56</b> <b>and that death occurred at</b> <b>3:50 PM</b> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>E. NALD D. BARK</b>				<b>ADDRESS</b> (Street, city, town, state) <b>M.D. VAH Ft. Howard, Md.</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>DATE THEREOF</b> <b>JAN 11, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National Cemetery Baltimore, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b>				<b>REGISTRAR'S SIGNATURE</b> <b>Dawson L. L...</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Cook-Blight Inc. Funeral Home</b>	
				<b>ADDRESS</b> <b>6009 Harford Road, Baltimore, Md.</b>		<b>DATE SIGNED</b> <b>1/7/56</b>	

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375 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00367

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

Item 11, Bill No. 1-11-56 et

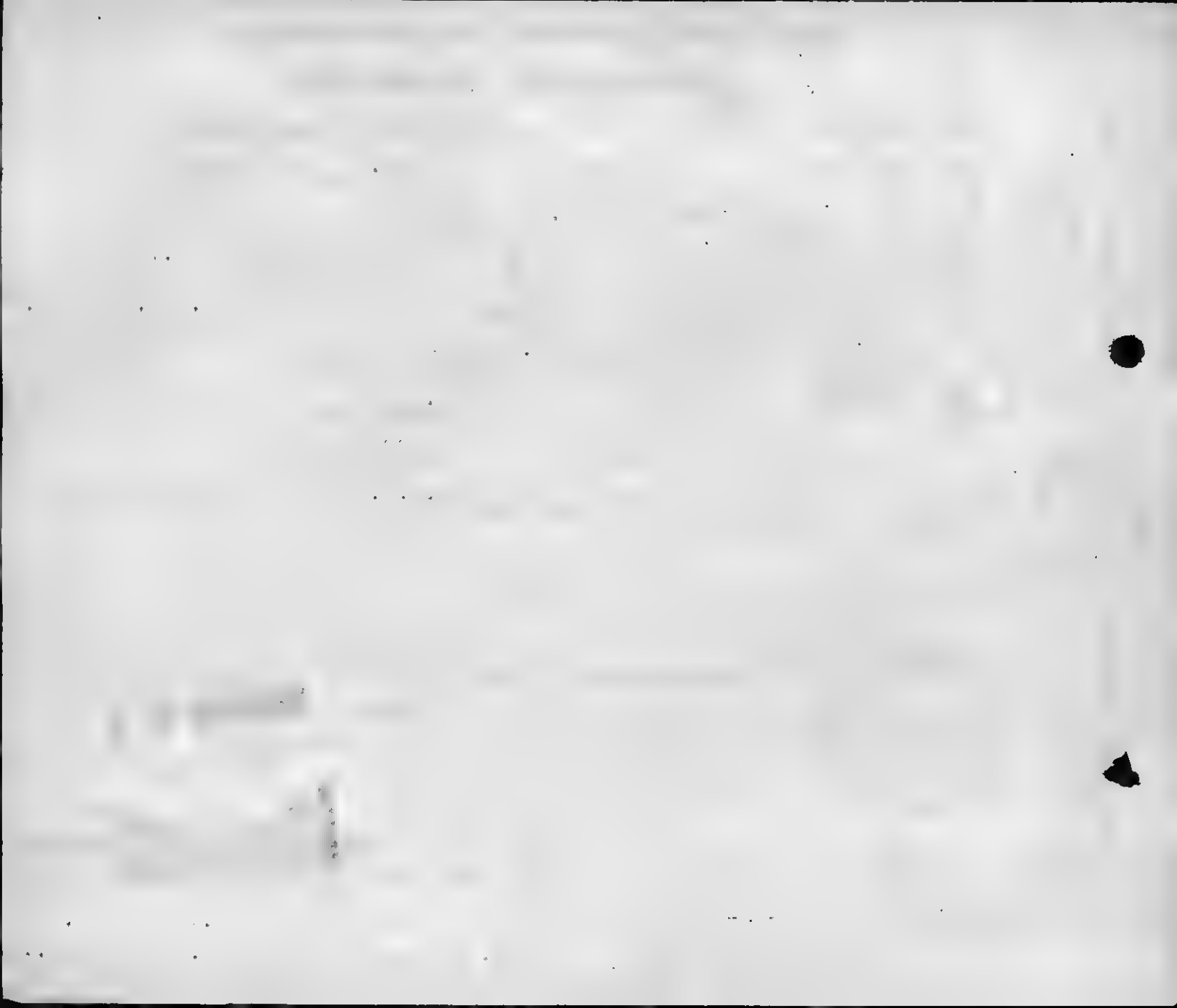
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
52 TOWN Catonsville Gardens		6 Mos.		TOWN Catonsville Gardens			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1528 Ingleside Ave				STREET ADDRESS (If rural give location) 1528 Ingleside Ave.,			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Joseph Snapp				4. DATE OF DEATH (Month) (Day) (Year) Jan. 17, 19 56.			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH Feb. 26, 1865	9. AGE last birthday 90 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Rebecca Clauser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mrs. H. H. Blackburn 1528 Ingleside Ave.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Cerebral thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 10, 19 56, to Jan. 17, 19 56, that I last saw the deceased alive on Jan. 15, 19 56, and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
SIGNATURE <i>J. Nelson McKay</i>				ADDRESS (Street, city, town, state) 6014 Edmonson Ave		DATE SIGNED Jan. 17, 1958	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-19-1956		NAME OF CEMETERY OR CREMATORY Good Shepherd		LOCATION (City, town, or county) Howard Co., Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>J. E. Henry</i>		25. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong		ADDRESS 3207 W. North Ave.,	
DATE Jan. 17, 1958							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M





**1** **INSTRUCTIONS** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00368

376

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cockeysville</u>		<u>10 yrs.</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home</u>				STREET ADDRESS <u>3621 Redwood Ave</u> (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Martha Ellen Snider</u>				<u>Jan. 27 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>		<b>9. AGE last birthday</b>	<b>10. IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<u>Female</u>	<u>white</u>	<u>Widowed</u>	<u>Dec. 11th, 1867</u>		<u>88</u> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Housewife</u>		<u>at home</u>		<u>Maryland</u>		<u>U.S.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>William H. Welton</u>				<u>Sarah J. Ayers</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
		<u>-</u>		<u>Elaine Dennis, Masonic Home</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>arteriosclerotic cardiovascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Oct 17, 1952</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Oct. 17, 1952</u> , <b>to</b> <u>Jan. 27, 1956</u> , <b>that I last saw the deceased alive on</b> <u>January 27, 1956</u> , <b>and that death occurred at</b> <u>8:55 P.M.</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Walter T. Ken</u>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
				<u>Cockeysville, Md</u>		<u>Jan 27, 56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>Burial</u>		<u>1/31/56</u>		<u>Lorraine Cemetery</u>		<u>Woodlawn, Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>114</u>		<u>Anna MacRae</u>		<u>Wm. Cook Inc.</u>		<u>1217 H Paul St</u>	
<b>DATE</b>							

100 - 100  
100 - 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

210  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00369  
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Lansdowne</u>		LENGTH OF STAY (in this place) <u>30 yrs</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Lansdowne</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>22 - 5th ave</u>				STREET ADDRESS (If rural, give location) <u>22 5th ave</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Annie</u> (Middle) <u>E. Snodgrass</u> (Last)				(Month) <u>July</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX: <u>7</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>		8. DATE OF BIRTH: <u>July 2 1884</u>	
9. AGE last birthday: <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, — if retired): <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Balto. Co Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa.</u>	
13. FATHER'S NAME: <u>James</u>				14. MOTHER'S MAIDEN NAME: <u>Annie O'Brien</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>216-03-2716</u>		17. INFORMANT & ADDRESS: <u>Edw A Short Jr 22 5th ave</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>Acute Cardiac failure</u>					
DUE TO					
Antecedent cause(s) (b) <u>Carcinoma Intestine</u>					
Diseases or conditions, if any, giving rise to the above cause (c) <u>stating underlying cause last</u>					
DUE TO					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Operation hysterectomy 1944</u>					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Dr. M. Kieffer</u> 1010 Trade Ave					
CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>July 17 56</u>					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>7/20/56</u>		NAME OF CEMETERY OR CREMATORY: <u>New Cathedral Cem.</u>	
LOCATION (City, town, or county) (State): <u>4300 Old Frederick Rd.</u>					
DATE REC'D BY LOCAL REG. <u>18-5-6</u>		REGISTRAR'S SIGNATURE: <u>John J. Cowan + Son</u>		24. FUNERAL DIRECTOR: <u>G. Gallis</u>	



377

## CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Randallstown</u>				TOWN <u>Randallstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Winans Road</u>				<u>Winans Road</u>			
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Harry</u>		<u>James</u>		<u>Snyder</u>		<u>Jan 30 19 56</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	10. IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>11/23/1883</u>	<u>72</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John George Snyder</u>				<u>Wilamena Florence Newman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>No</u>		<u>220-05-9860A Mrs Ella May Snyder</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death	
Immediate cause (a) <u>Lymphosarcoma - Stomach</u> Antecedent causes (s) (b) <u>DUE TO</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>				<u>One Year.</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 19 49</u> , to <u>Jan 30, 19 56</u> , that I last saw the deceased alive on <u>1/30, 19 56</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.					
SIGNATURE <u>Edmund G. Prigmore M.D.</u>		ADDRESS <u>2204 Gilbreth Rd, Balt, Md.</u>		DATE SIGNED <u>1/30/56</u>	
23. BURIAL, CREMATION, REMOVAL		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>2/2/56</u>		<u>Mt. Olive</u>	
DATE RECD BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>Jan 10, 1956</u>		<u>Marion A. Newell</u>		<u>James H. Newell - Gilbreth Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 7 1952

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00371

202

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>DUNDALK (22)</u>		<u>15 YRS</u>		TOWN <u>DUNDALK (22)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GLENHURST RD</u>				STREET ADDRESS (If rural give location) <u>GLENHURST RD</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MILDRED</u> (Middle) <u>LUTHARDT</u> (Last) <u>SNYDER</u>				(Month) <u>1</u> (Day) <u>29</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>3 JUNE 1899</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRIAL FEED</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES LUTHARDT</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH HILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-098037</u>		17. INFORMANT & ADDRESS <u>JAMES G. SNYDER - SAME</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Ch of liver</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 MGS</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 20<sup>th</sup> 1955</u> to <u>Jan 12<sup>th</sup> 1956</u> , that I last saw the deceased alive on <u>Nov 20<sup>th</sup> 1955</u> , and that death occurred at <u>1-29-56</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Jack Chellus</u>		M.D. <u>BALTO 7-2</u>		ADDRESS (Street, city, town, state) <u>216 Hurstyn</u>		DATE SIGNED <u>1-31-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-2-56</u>		NAME OF CEMETERY OR CREMATORY <u>LENDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dawson L. Loring</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Duke Proby, Rndell, MD</u>		ADDRESS	
DATE <u>Feb. 2, 1956</u>							





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

378

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

00372

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorenson Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>3734 Beech Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mellie</u> (Middle) <u>Kelly Stack</u> (Last) <u>Snyder</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>January 29 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 28, 1890</u> 9. AGE last birthday <u>65</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph D. Stack</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Neville</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Wm. H. Carroll</u>		<u>Lutherville, Md.</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Cerebrovascular Accident</u> Antecedent cause(s) <u>Central arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			<u>1 month</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at work <input type="checkbox"/> Nnt while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>M. Morgan</u>		ADDRESS <u>15 E. Biddle St Baltimore Md.</u> DATE SIGNED <u>1/31/56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>		DATE THEREOF <u>2/1/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG. <u>50</u>		REGISTRAR'S SIGNATURE <u>W. W. Meeks</u> ADDRESS <u>Box 805 N. Calvert St.</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

00373

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1009 Augusta Ave</u>		STREET ADDRESS (If rural, give location) <u>1809 Augusta Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Marcvanna</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>16</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 16, 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>86</u> yrs. If under 1 year: Months <u>8</u> Days <u>7</u> If under 24 hrs: Hours <u>1</u> Min. <u>16</u>
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Poremski</u>		14. MOTHER'S MAIDEN NAME <u>Anna</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT AND ADDRESS <u>Frances Sobus 1809 Augusta Ave.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>15 days</u> <u>1 year</u>
Immediate cause (a)....	<u>myocarditis, acute</u>	
Antecedent cause(s) (b).... Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	<u>atherosclerosis</u> <u>myocarditis, chronic</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Jan 15, 1956, to Jan 16, 1956, that I last saw the deceased alive on Jan 15, 1956, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

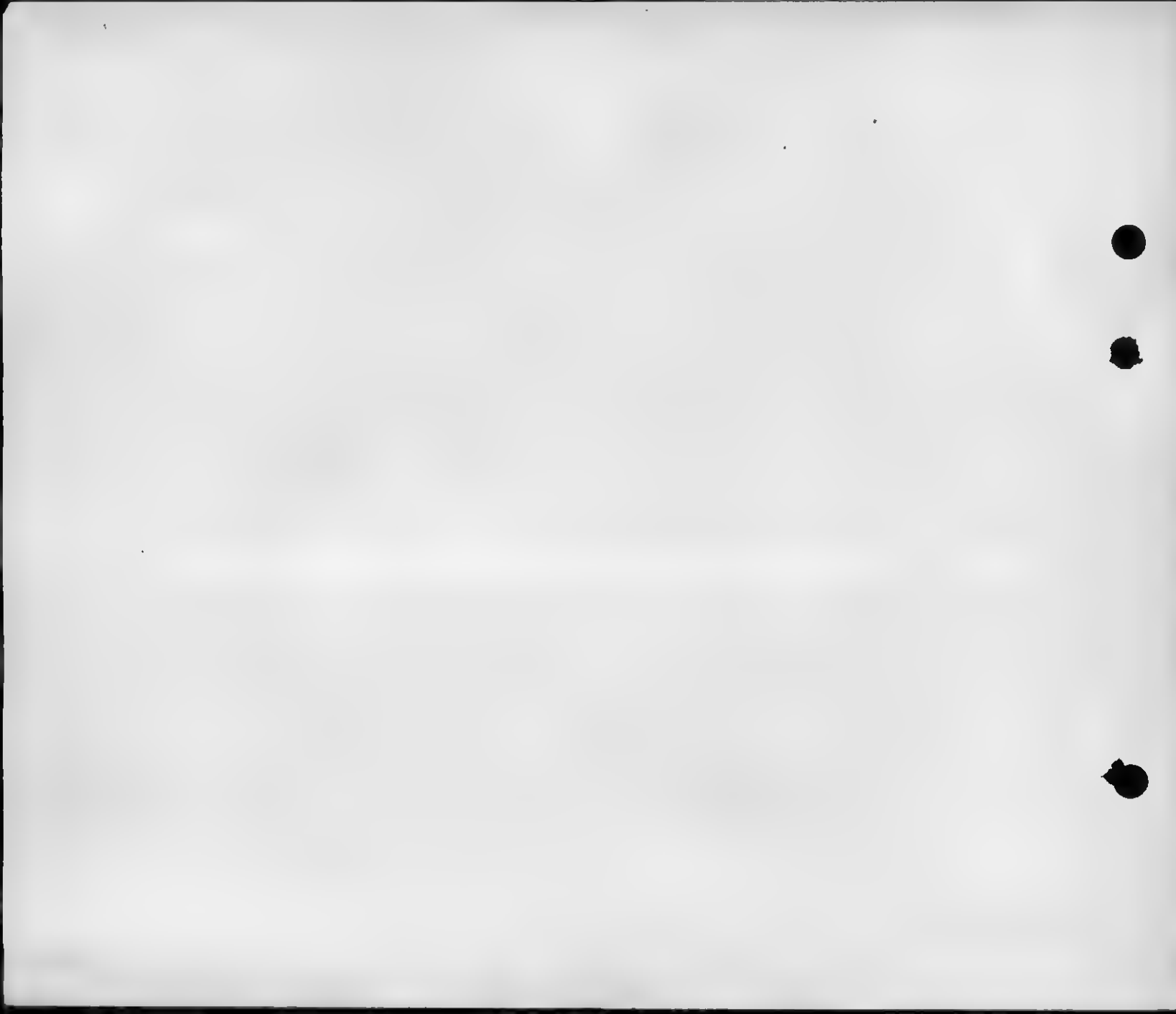
SIGNATURE Harold H. Andrew ADDRESS 33 DUNDON AVE BALTIMORE 22 DATE SIGNED 1/16/56

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1-19-1956</u>	NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>	LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>1/17/56</u>	REGISTRAR'S SIGNATURE <u>Harold H. Andrew</u>	24. FUNERAL DIRECTOR <u>Walter J. Schumaker</u> ADDRESS <u>1010 DUNDON AVE BALTIMORE</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u> MARYLAND		STATE <u>Md</u> COUNTY <u>Balto</u>		CITY: If outside corporate limits, write RURAL and give nearest town OR TOWN <u>Parkville</u>		CITY: If outside corporate limits, write RURAL and give nearest town OR TOWN <u>Parkville</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parkville</u>		LENGTH OF STAY (In this place) <u>2 yrs.</u>		STREET ADDRESS (If rural give location) <u>7823 Clarkworth Pl.</u>		STREET ADDRESS <u>7823 Clarkworth Pl.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Anna Stassick</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>Jan 18 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>1885</u> <u>70</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>House work</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>At Home</u>		11. BIRTHPLACE (State or foreign country): <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>Radjo wonchick</u>				14. MOTHER'S MAIDEN NAME: <u>Anna</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT & ADDRESS: <u>Vivian T. Little 7823 Clarkworth Pl.</u>							
15. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						<u>1 day</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/10</u> <sup>1956</sup> , to <u>1/17</u> <sup>1956</sup> , that I last saw the deceased alive on <u>1/16</u> <sup>1956</sup> , and that death occurred at <u>1:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Harold E. Graft</u>				ADDRESS <u>8100 Hanford Rd</u>		DATE SIGNED <u>1/18/56</u>	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JAN 20 1956</u>		NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEM.</u>		LOCATION (City, town, or county) (State) <u>CLINTON N.Y.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>19-58</u>		REGISTRAR'S SIGNATURE <u>J.W. Adair</u>		24. FUNERAL DIRECTOR ADDRESS <u>Doppel Bros. 7110 Belair Rd</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



380

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

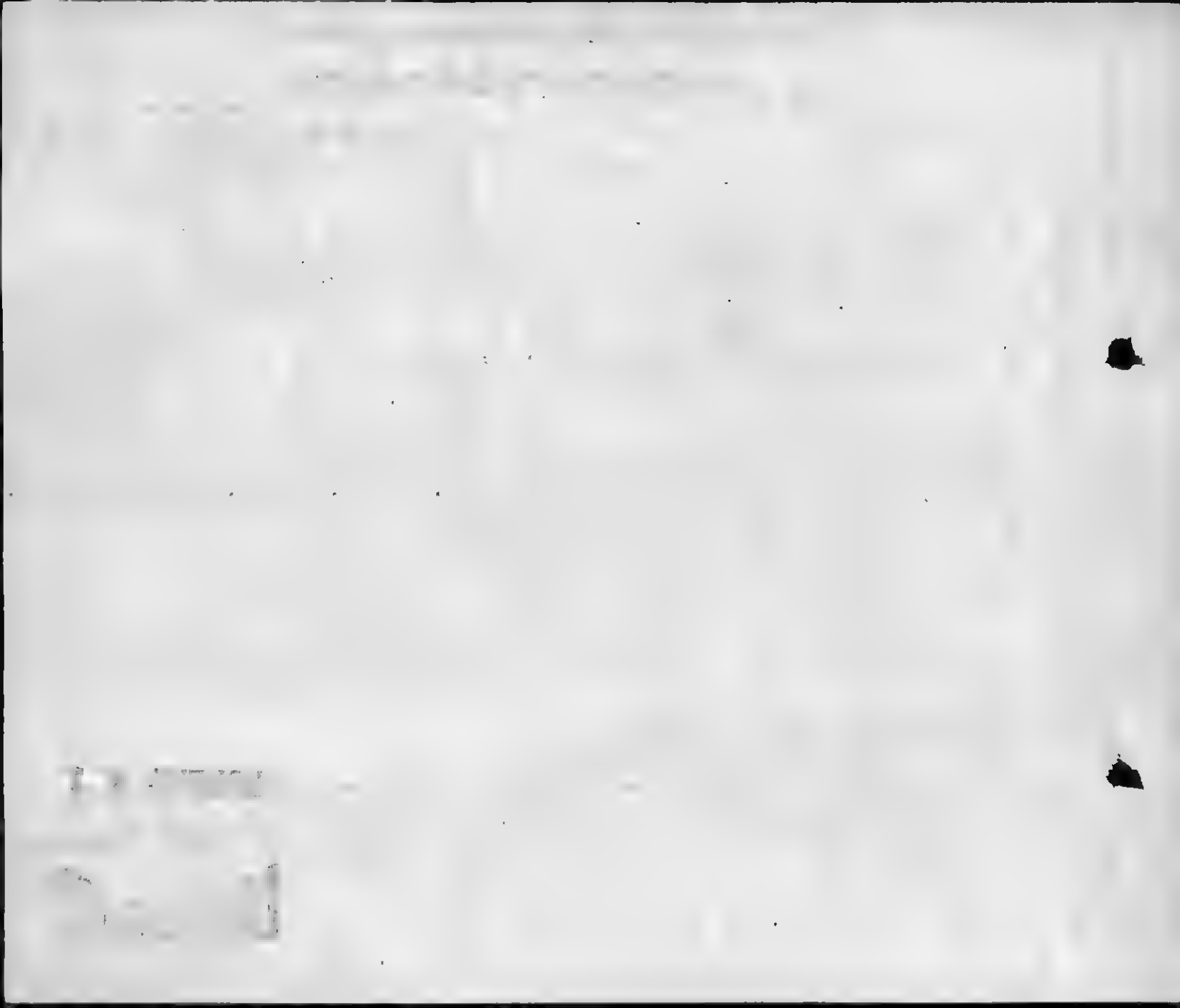
<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		LENGTH OF STAY (In this place) <b>MARYLAND</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1013 Regester Avenue</b>				STREET ADDRESS (If rural give location) <b>1013 Regester Avenue</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Mrs. Bertha Frances Stevens</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>January 30th 19 56</b>			
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>widowed</b>	<b>8. DATE OF BIRTH</b> <b>Oct. 28, 1874</b>		<b>9. AGE last birthday</b> <b>81 yrs.</b>	<b>IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>at home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Champlain, New York</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Joseph Barker</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Baker</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. Wynne A. Stevens, 1013 Regester Ave.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>4. IMMEDIATE CAUSE (A)</b> <b>ANTECEDENT CAUSE(S) DUE TO</b> <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>				<b>Cerebral arteriosclerosis</b> <b>Generalized arteriosclerosis</b>		<b>unknown</b> <b>unknown</b>	
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Jan 27, 1956, to Jan 30, 1956, that I last saw the deceased alive on Jan 27, 1956, and that death occurred at 7:00 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Fredrick J. Vallner</i>		<b>DATE THEREOF</b> <b>Feb. 2, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Green Mount Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Baltimore, Maryland</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Cremation</b>		<b>24. REC'D BY REGISTRAR</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck, 5305 Harford Road #14</b>		<b>ADDRESS</b>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 11 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M





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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

381

## CERTIFICATE OF DEATH

00376

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>MARYLAND</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <i>Cockeysville</i>				TOWN <i>BALTIMORE</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Masonic Home</i>				STREET ADDRESS (If rural give location) <i>1002 FREDERICK ROAD</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>IDA</i> (Middle) <i>M.</i> (Last) <i>Stoddard</i>				(Month) <i>Jan</i> (Day) <i>20</i> (Year) <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>MARCH 1, 1872</i>	9. AGE last birthday <i>83</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Henry Correns</i>				14. MOTHER'S MAIDEN NAME <i>Satherine Stumpf</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT & ADDRESS <i>L. Shaw Jones, Masonic Home</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Multiple Lympho-Carcinoma</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Oct. 29, 1955</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>JUNE 2</i> , 19 <i>54</i> , to <i>Jan. 20</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Jan. 18</i> , 19 <i>56</i> , and that death occurred at <i>8</i> A.M., from the causes and on the date stated above.							
SIGNATURE <i>Walter T. Jones</i>				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>				DATE THEREOF <i>1/23/56</i>		NAME OF CEMETERY OR CREMATORY <i>WOODEN PARK CEMETERY</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Frank L. Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook Inc</i>		ADDRESS <i>1217 ST. PAUL ST</i>	
DATE <i>Jan. 23, 1956</i>							



382

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Carroll</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Cockeysville</i>		<i>Nov. 5, 1941</i>		TOWN <i>Westminster, Md</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Masonic Home</i>				STREET ADDRESS (If rural give location) <i>31 Colonial Ave</i>			
3. NAME OF DECEASED (Type or Print) <i>George E. Sullivan</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Jan 30 1956</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>		8. DATE OF BIRTH <i>Nov. 7, 1867</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Somerset</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>		9. AGE last birthday <i>88</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>Westminster, Md</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>James Sullivan</i>				14. MOTHER'S MAIDEN NAME <i>Amelia Brown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>-</i>				16. SOCIAL SECURITY NO. <i>-</i>			
17. INFORMANT & ADDRESS <i>Shaw Dennis Cockeysville, Md</i>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>arterio sclerotic Cardiovascular disease</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Nov. 5, 1941</i> , to <i>Jan. 30, 1956</i> , that I last saw the deceased alive on <i>Jan. 30, 1956</i> , and that death occurred at <i>9:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Walter T. Kees</i>				ADDRESS (Street, city, town, state) DATE SIGNED			
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/2/56</i>		NAME OF CEMETERY OR CREMATORY <i>Kreider's Cemetery</i>		LOCATION (City, town, or county) (State) <i>Carroll County, Maryland</i>	
24. REC'D BY REGISTRAR <i>Frank Smith</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook, Inc.</i>		ADDRESS <i>1512 St Paul St</i>	
DATE <i>Feb. 4, 1956</i>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55

RECEIVED

FEB 1 1950

383

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>5000</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SHADY BROOK NURSING HOME</u>	STATE <u>MD</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> OR TOWN STREET ADDRESS (If rural give location) <u>742 PRAIRIE AVE</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last) <u>HARRY B. SUMMERS</u>		OF DEATH: <u>1-25</u> 19 <u>58</u>	
5. SEX <u>M</u> COLOR OR RACE <u>WHITE</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1-13-1913</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		9. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min. <u>45</u> yrs.	
10B. KIND OF BUSINESS OR INDUSTRY <u>IN. SEC</u>		11. BIRTHPLACE (State or foreign country): <u>MD</u>	
13. FATHER'S NAME <u>HARRY B. SUMMERS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		17. INFORMANT & ADDRESS <u>HARRY B. SUMMERS</u>	
16. SOCIAL SECURITY NO. <u>1-26-56</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CEREBRAL VASCULAR ACCIDENT</u>			
ANTECEDENT CAUSE (B) <u>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>TERMINAL PNEUMONIA</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/11</u> , 19 <u>58</u> to <u>1/25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/25</u> , 19 <u>58</u> , and that death occurred at <u>5:00 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>John H. Shaw</u>		DATE SIGNED <u>1/26/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		NAME OF CEMETERY OR CREMATORY <u>5800 EDMONDSON AVE.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-26-58</u>		24. FUNERAL DIRECTOR ADDRESS <u>WILLIAM J. JONES</u>	
REGISTRAR'S SIGNATURE <u>V.E. Harvey</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. AIR FORCE

100-100000-100000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

384

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00379

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

Item 9, File 711-23-46 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essex, Baltimore 21</u>	
TOWN <u>Essex</u>		TOWN <u>Baltimore 21</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>505 Essex Ave</u>		STREET ADDRESS (If rural give location) <u>505 Essex Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Anna</u>	<u>Agnes</u>	<u>SWEET</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb 14 1889</u>
9. AGE last birthday <u>66</u> yrs.		10. AGE last birthday <u>66</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George A Smith</u>		14. MOTHER'S MAIDEN NAME <u>Amey E Kirk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>214-34-2969</u>	
17. INFORMANT <u>Pauline Demond</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>151X</u> Immediate cause (a) <u>Metastatic carcinoma</u> Antecedent cause(s) (b) <u>Carcinoma of stomach</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> <u>9 mo</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED	
OF INJURY		While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 24, 1955</u> , to <u>Jan 12, 1956</u> , that I last saw the deceased alive on <u>Dec 29, 1955</u> , and that death occurred at <u>7:30 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Joseph Quick MD</u>		ADDRESS <u>423 Eastern Ave</u>	
DATE SIGNED <u>1/13/56</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>1-16-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Silverbrook</u>		LOCATION (City, town, or county) (State) <u>Lanark Ave, Wil, Del</u>	
24. FUNERAL DIRECTOR <u>Joseph A Grant</u>		ADDRESS <u>North East Md</u>	

U. S. A.

DEAD



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

385

00389

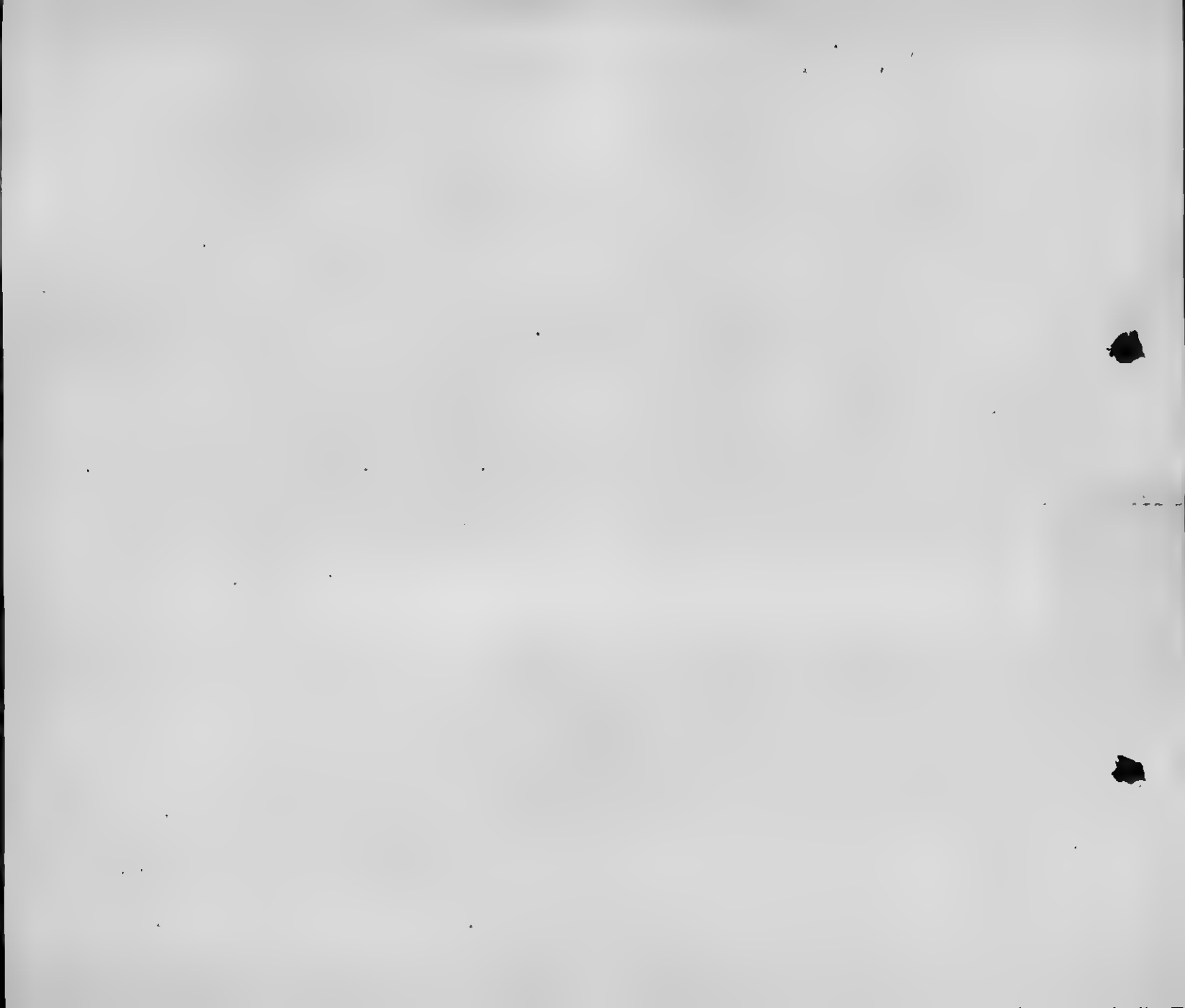
Reg. Dist.

No. 21

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Brooklyn</u>		<u>7</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1724 Hill an</u>				STREET ADDRESS (If rural, give location) <u>1724 Hill an</u>			
<b>3. NAME OF DECEASED:</b> (First) <u>Leonora</u>		(Middle) <u>A</u>		(Last) <u>TAFT</u>		<b>4. DATE OF DEATH</b> (Month) <u>July</u> (Day) <u>22</u> (Year) <u>1956</u>	
<b>5. SEX:</b> <u>F</u>	<b>6. COLOR OR RACE:</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED,</b> <u>Married</u>		<b>8. DATE OF BIRTH:</b> <u>Aug. 17, 1885</u>		<b>9. AGE last birthday:</b> <u>70</u> yrs. (If UNDER 1 YEAR, Months Days Hours Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <u>Christian Scientist Practitioner</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY:</b>		<b>11. BIRTHPLACE</b> (State or foreign country): <u>Maryland</u>	
<b>13. FATHER'S NAME:</b> <u>Campan</u>				<b>14. MOTHER'S MAIDEN NAME:</b> <u>Mary --</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY No.:</b> <u>no</u>		<b>17. INFORMANT &amp; ADDRESS:</b> <u>Mr. Robert S. Taft - 1724 Hill Drive, Wood-</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>							
Immediate cause (a)..... <u>Acute cardiac failure</u>							
DUE TO							
Antecedent cause(s) (b)..... <u>Cardiovascular disease</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION:</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>				<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></b>		<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY</b>		<b>21c. (City or town) (County) (State)</b>			
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
SIGNATURE <u>W. M. Kieffer</u>		1010 <u>Leeds on</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-22-56</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <u>Burial - Cremation</u>		<b>DATE THEREOF:</b> <u>1/23/56</u>		<b>NAME OF CEMETERY OR CREMATORY:</b> <u>Loudon Park Cem. Crematory</u>		<b>LOCATION (City, town, or county) (State):</b> <u>Baltimore, Md.</u>	
<b>DATE REC'D BY LOCAL REG.</b> <u>1/23/56</u>		<b>REGISTRAR'S SIGNATURE:</b> <u>W. M. Kieffer</u>		<b>24. FUNERAL DIRECTOR:</b> <u>Wm. J. Lickner</u>		<b>ADDRESS:</b> <u>1724 Hill Drive, Baltimore, Md.</u>	



386

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince George</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>T.B.</u>			
TOWN <u>Catonsville</u>		<u>4yr2mos23days</u>		STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>William Joseph Tebbs</u>				<u>January 17, 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Separated</u>	<u>11-2-1891</u>	<u>64</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Steam Plumber</u>				<u>New York</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William Charles Tebbs</u>				<u>Martinie Donelson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Unknown</u>				<u>Unknown</u>		<u>Records Spring Grove State Hospital</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <u>Coronary thrombosis</u>			
ANTECEDENT CAUSE (B)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Chronic cardiac failure</u>			
				DUE TO			
				(C) <u>Arteriosclerotic cardiovascular disease</u>			
				Years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7-... , 1953 to 1-17-... , 1956 that I last saw the deceased alive on 1-17-... , 1956, and that death occurred at 10 P. M. from the causes and on the date stated above.							
SIGNATURE <u>Stella Wachler</u>				DATE SIGNED <u>1-18-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Jan 20 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	
24. FUNERAL DIRECTOR <u>Martin W. Hyman &amp; Co</u>				LOCATION (City, town, or county) <u>Arlington</u>		(State) <u>MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-18-56</u>				REGISTRAR'S SIGNATURE <u>T.E. Harz...</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LOREAU V. E.

1910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

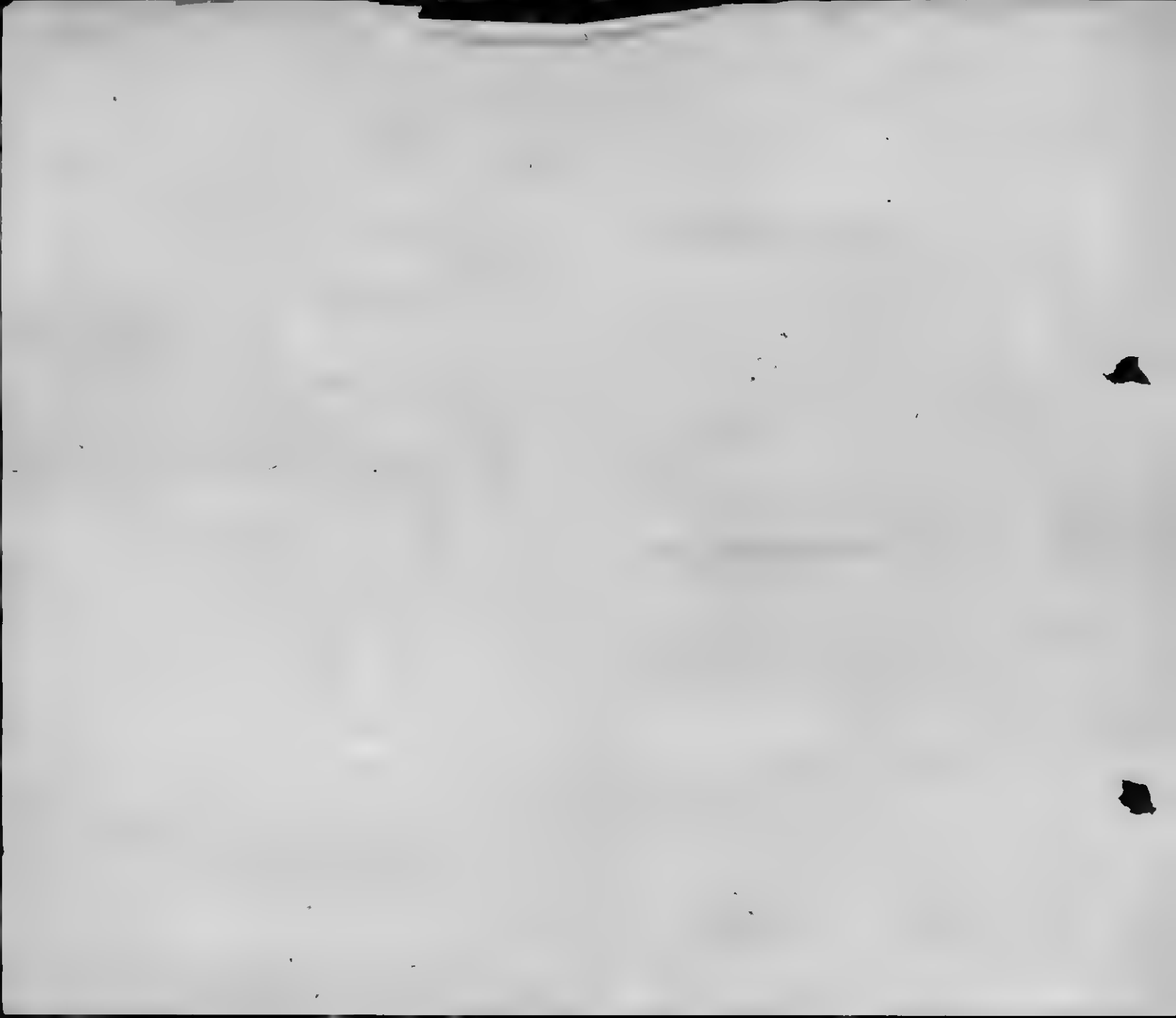
# 387

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 00382

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Middle River</u>				TOWN <u>Middle River</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>950 Bengies Road</u>				STREET ADDRESS (If rural, give location) <u>950 Bengies Road</u>			
3. NAME OF DECEASED:		(First) <u>MARtha</u>		(Middle)		(Last) <u>Thomas</u>	
(Type or Print)						4. DATE OF DEATH	
						(Month) <u>1</u> (Day) <u>2</u> (Year) <u>1966</u>	
5. SEX: <u>+</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>JULY 15 - 1920</u>		9. AGE last birthday: <u>45</u> yrs.	
						IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Greensboro N. C.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Sandy Winchester</u>				14. MOTHER'S MAIDEN NAME: <u>Ada Van Kester</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>James Thomas 930 Bengies Road</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
44xx Immediate cause (a) <u>Hypertensive Cardiac Association</u> DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY		21c. (City or town) (County)		(State) <u>MD</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8/1/66</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Jan 15/66</u>		NAME OF CEMETERY OR CREMATORY: <u>Mt. Calvary Cem.</u>		LOCATION (City, town, or county) (State): <u>A.A. County Md.</u>	
DATE REC'D BY LOCAL REG. <u>3-55</u>		REGISTERER'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
				<u>Mrs. Robert A. Elliott, Daughter</u>		<u>1129 N. Caroline St</u>	



211

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY		Baltimore		STATE		Md.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		Arbutus		COUNTY		Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		4307 Wilkens Ave		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Arbutus	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		4307 Wilkens Ave		STREET ADDRESS		4307 Wilkens Ave	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Dr. John Frederick Timmes				Jan. 21, 1956			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
male	White	Married	June 29, 1877	78	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Med. Doctor		Self		Brooklyn, N.Y.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John Timmes				Barbara Hafer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
				none		Marie Timmes, 4307 Wilkens Ave	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Lymphosarcoma with metastasis						6 months	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause inst							
(c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, generalized							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
21. ACCIDENT (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE				INJURY			
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)				INJURY OCCURRED While at Not while work at work		HOW DID INJURY OCCUR?	
OF INJURY				M.			
22. I hereby certify that I attended the deceased from July 1953, to Jan. 21, 1956, that I last saw the deceased alive on 1/17, 1956, and that death occurred at 8:10 a.m., from the causes and on the date stated above.							
SIGNATURE				(DEGREE OR TITLE)		DATE SIGNED	
Herbert J. Derickas, M.D.				5305 East Drive		Arbutus - 27, Md. 1/21/56	
23. BURIAL, CREMATION REMOVAL (Specify):				DATE THEREOF		NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)	
Burial				1-24-56		Most Holy Trinity Brooklyn, N.Y.	
DATE REC'D BY LOCAL REG.				REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
Jan 21 56				Geo Kieffer		Howard H. Hubbard, 4107 Wilkens Ave	

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. A. 1950

1950



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00384

388

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>BALTIMORE</b>		STATE <b>MARYLAND</b>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>FORT HOWARD</b>		<b>21 DAYS</b>		TOWN <b>BALTIMORE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>4118 COLEMAN AVENUE</b>			
3. NAME OF (First) <b>MARK</b> (Middle) <b>D.</b> (Last) <b>TRACY</b>		4. DATE (Month) (Day) (Year) <b>January 17 19 56</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>		8. DATE OF BIRTH <b>October 26, 1896</b>		9. AGE last birthday <b>59</b> yrs.		IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		11. BIRTHPLACE (State or foreign country) <b>Rushford, Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Michael Tracy</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Hennesey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>Yes</b> (If Yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>213-12-8987</b>		17. INFORMANT & ADDRESS <b>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						3 MONTHS	
196X IMMEDIATE CAUSE (A) <b>CHONDROSARCOMA, LEFT HIP WITH METASTASIS TO LUNGS AND HEART</b>							
ANTECEDENT CAUSE(S) <b>XXXX</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <b>11/15/55</b>		19b. MAJOR FINDINGS OF OPERATION <b>Disarticulation left leg</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>M.</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Dec. 27, 19 55</b> to <b>Jan. 17, 19 56</b> and that death occurred at <b>11:35 PM</b> from the causes and on the date stated above.							
SIGNATURE <b>Donald D. Mark, M. D.</b>				ADDRESS (Street, city, town, state) <b>VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>1/18/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1-21-56</b>		NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. REC'D BY REGISTRAR <b>Jan. 19, 1956</b>		REGISTRAR'S SIGNATURE <b>Lawrence H. ...</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. Md.</b>			

U. S. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 2, Film 193 2-23-55 -t  
389 CERTIFICATE OF DEATH

01545

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		LENGTH OF STAY (In this place) <u>3yrs. 10dys.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore/Catonsville</u> Washington D. C.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE STATE HOSP.</u>				STREET ADDRESS <u>220 Colorado St.</u> (If outside city location) <u>Mercy Villa / Baltimore, Md.</u>			
3. NAME OF DECEASED: (First) <u>Ida</u>		(Middle) <u>Elizabeth</u>		(Last) <u>Tyler</u>		4. DATE OF DEATH: (Month) <u>Jan.</u> (Day) <u>25</u> (Year) <u>1956</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Feb. 28, 1873</u>	9. AGE last birthday: <u>82</u> yrs	10. UNDER 1 YEAR: Months <u></u> Days <u></u>	11. UNDER 1 YEAR: Months <u></u> Days <u></u>	12. UNDER 1 YEAR: Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housekeeper</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
13. FATHER'S NAME: <u>William Tyler</u>				14. MOTHER'S MAIDEN NAME: <u>Frances</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unknown</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS: <u>Spring Grove Hospital records</u>	
15. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>							
ANTECEDENT CAUSE (B) <u>Chronic cardiovascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Generalized arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July, 1953</u> , to <u>Jan. 25, 1956</u> , that I last saw the deceased <u>alive on</u> , 19, and that death occurred at <u>145</u> M. from the causes and on the date stated above.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>buried</u>		<u>2/16/56</u>		<u>Spring Grove State Hosp. Catonsville 28 Md.</u>		<u>Med.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2/16/56</u>		<u>T.E. Hurray</u>		<u>Spring Grove State Hosp Catonsville 28 Md.</u>		<u>Med.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1990

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

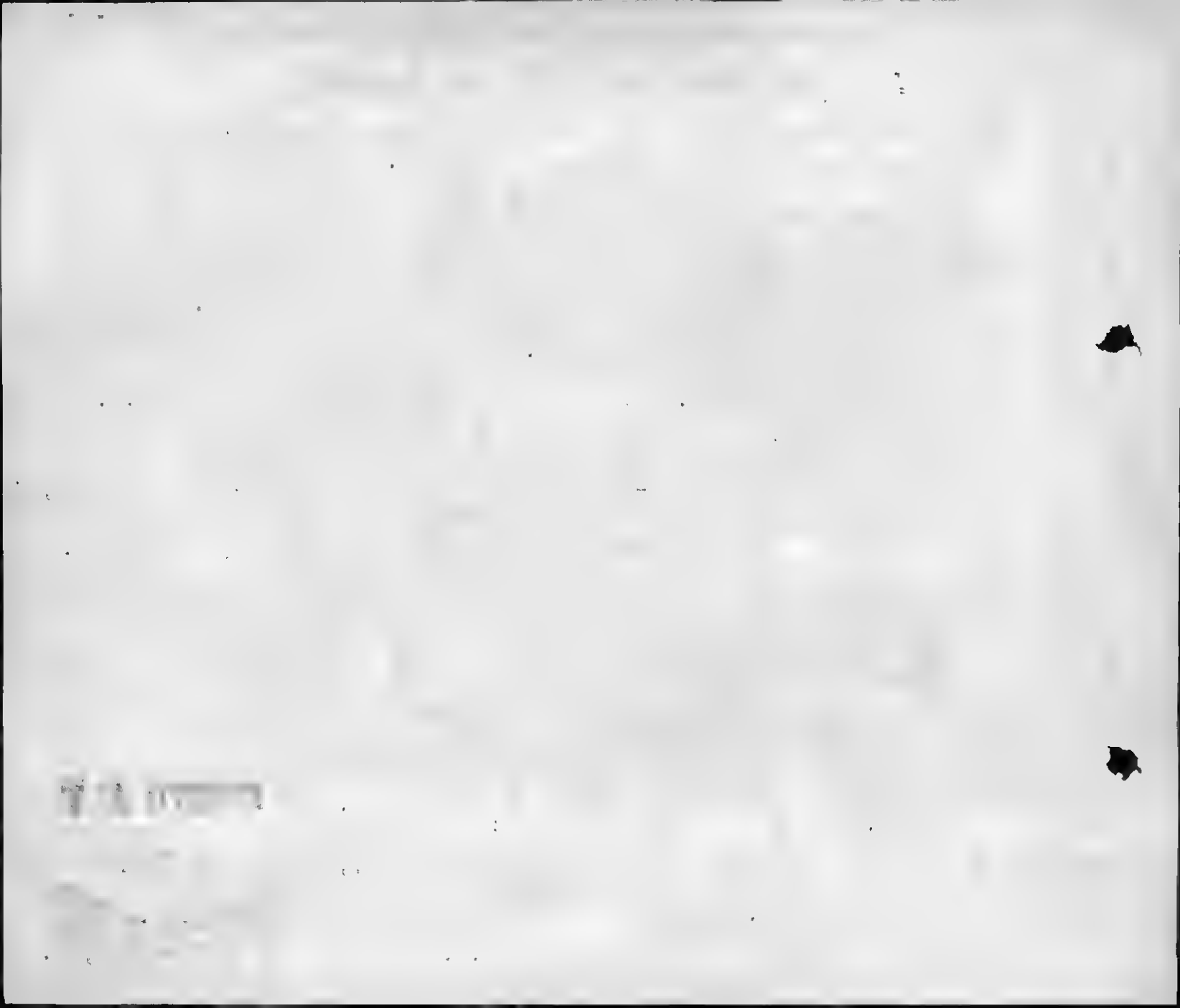
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00385

## 390 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pleasant Hill Road</b>				STREET ADDRESS (If rural give location) <b>Pleasant Hill Road</b>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>John Conrad Uhler</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 18 19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 1, 1871</b>	9. AGE last birthday <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Western Md. R.R.</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Charles Uhler</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Lorey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-7387</b>		17. INFORMANT & ADDRESS <b>Elizabeth H. Uhler, Owings Mills, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4. IMMEDIATE CAUSE (A) <b>Gangrene of both feet</b>						3 mos.	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Generalized arteriosclerosis</b>						8 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Prostatic hypertrophy with urinary retension</b>						3 days	
19a. DATE OF OPERATION <b>none</b>		19b. MAJOR FINDINGS OF OPERATION <b>none</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <b>none</b>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <b>none</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>none</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>none</b>			
22. I hereby certify that I attended the deceased from <b>June 30, 1939</b> to <b>Jan. 18, 1956</b> , that I last saw the deceased alive on <b>Jan. 17, 1956</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>D. D. Eline</b>				DATE SIGNED <b>6 Hanover Rd., Reisterstown, Md. 1-19-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Jan. 21, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
24. REC'D BY REGISTRAR <b>1-20-56</b>		REGISTRAR'S SIGNATURE <b>Mary B. Zline</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>			



## CERTIFICATE OF DEATH

Reg. Dist. No.

391

## 1. PLACE OF DEATH:

COUNTY **Baltimore** MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR **Owings Mills** LENGTH OF STAY  
 TOWN **2 yrs.**  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS **Rosewood State Tr. School**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN **Baltimore**  
 STREET ADDRESS (If rural give location)  
**3301 Hamilton Avenue**

## 3. NAME OF DECEASED:

(First) **Joseph** (Middle) **N.** (Last) **Vogel**

4. DATE (Month) (Day) (Year)  
 OF DEATH: **1 27 19 56**

## 5. SEX:

**male**

6. COLOR OR RACE:  
**white**

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)  
**single**

8. DATE OF BIRTH  
**1/1/54**

9. AGE last birthday: **2 yrs** IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

## 10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):  
**Baltimore, Maryland**

12. CITIZEN OF WHAT COUNTRY?  
**U.S.A.**

## 13. FATHER'S NAME:

**William H. Vogel**

## 14. MOTHER'S MAIDEN NAME:

**Margaret Anne Cellini**

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

**Rosewood Records, Owings Mills, Md.**

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

(A)

**Acute Bronchitis - Broncho Pneumonia**

## INTERVAL BETWEEN ONSET AND DEATH

**1 day**

## ANTECEDENT CAUSE (S):

DUE TO

(B)

**Congenital Malformation of central****since birth**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

DUE TO

(C)

**nervous system (hydroanencephaly)**

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☒

## 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

## 21C. WHERE DID (City or town) (County) (State)

INJURY OCCUR?

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **1/27**, 19 **56**, to **1/27**, 19 **56**, that I last saw the deceased

alive on **1/27**, 19 **56**  
 SIGNATURE **Harry S. Butler, M.D.**

and that death occurred at **8:40 a.m.**, from the causes and on the date stated above.

ADDRESS

DATE SIGNED

**Owings Mills, Md.****1/27/56**

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county) (State)

**Burial****Jan. 30, 1956****Parkwood Cemetery****Baltimore, Maryland**

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

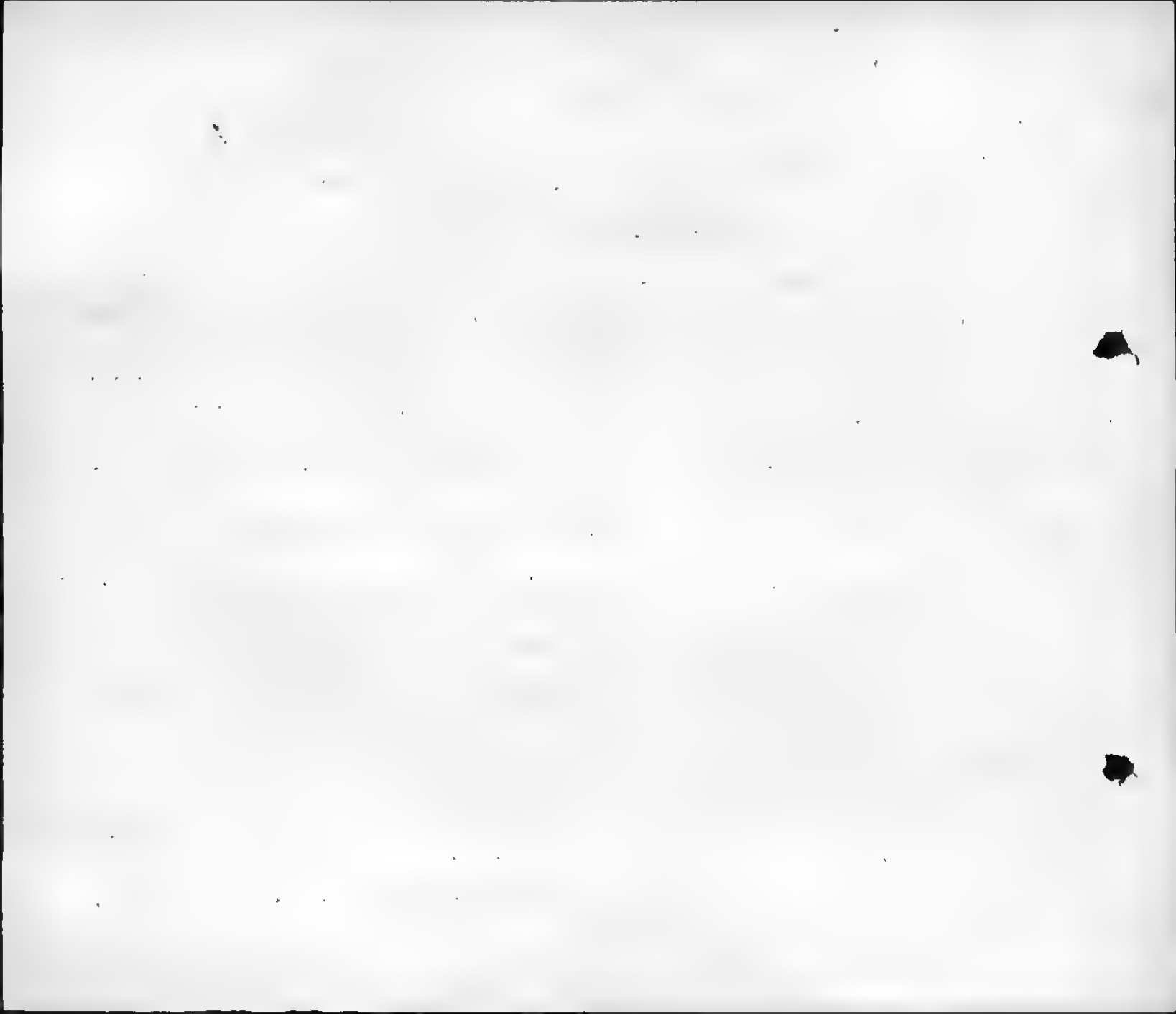
## 24. FUNERAL DIRECTOR

## ADDRESS

**Leonard J. Ruck, 5305 Harford Road #14**

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

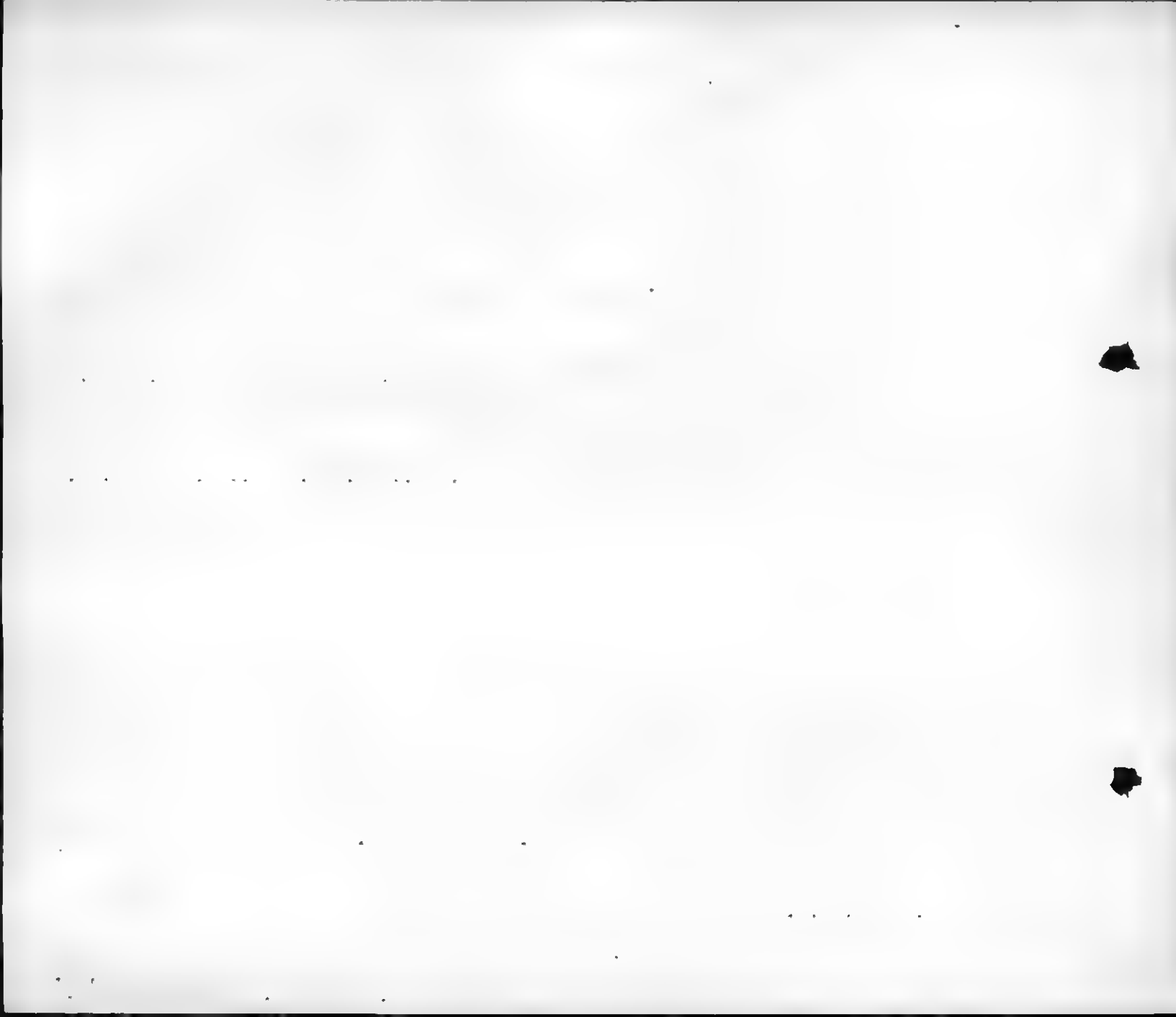
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 392 CERTIFICATE OF DEATH

Reg. Dist. No.

00387

1 PLACE OF DEATH.		2 USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>MARYLAND</b>	COUNTY <b>0</b>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>FORT HOWARD</b>	LENGTH OF STAY (in this place) <b>109 DAYS</b>	CITY: If outside corporate limits, write RURAL and give nearest town TOWN <b>BALTIMORE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>		STREET ADDRESS (If rural give location) <b>318 SOUTH WASHINGTON STREET</b>	
3. NAME OF DECEASED: (Type or Print) <b>JOHN F. WANTROBE</b>		4. DATE OF DEATH: (Month) (Day) (Year) <b>JANUARY 18 19 56</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>June 14, 1896</b>
9. AGE last birthday: <b>59</b> yrs		10. UNDER 1 YEAR: Months Days	11. UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Zinc smelter</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Steel Company</b>	
11. BIRTHPLACE (State or foreign country): <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME: <b>Frank Wantrobe</b>		14. MOTHER'S MAIDEN NAME: <b>Margaret MN: Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): (If Yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO.: <b>Unknown</b>	
17. INFORMANT & ADDRESS: <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>BRONCHOGENIC CARCINOMA, RIGHT UPPER LOBE</b>			<b>1 1/2 YEARS</b>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
21e. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>VA M.</b>		21f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>Oct. 1, 1955, to Jan. 1, 1956</b> , and that death occurred at <b>2:40 PM</b> , from the causes and on the date stated above.			
SIGNATURE <b>Donald D. Mark, M.D.</b>		ADDRESS <b>M.D. VAH, FORT HOWARD, MARYLAND</b>	
DATE SIGNED <b>1/19/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1/23/56</b>	
NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Michael A. Sadowski, 1808 Eastern Ave.</b>			



00388

MARYLAND

393

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Baltimore</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>rural</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor</u>		STREET ADDRESS (If rural, give location) <u>Northway apt. 3700 n. Charles St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Anna C. E. Wehr</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>7</u> (Year) <u>1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Jan 20 1879</u>
9. AGE last birthday <u>76</u> yrs.		10. IF under 1 year Months <u>1</u> Days <u>7</u> Hours <u>19</u> Min.	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OR, WHAT COUNTRY? <u>Balto. City</u>	
13. FATHER'S NAME <u>Martin Meyerdirek</u>		14. MOTHER'S MAIDEN NAME <u>Meyerdirek, Anna Felber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Helen W. Bartlett, daughter, Easton, Md</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)....

metastatic carcinoma

Antecedent cause(s)

(b)....

Carcinoma of breast

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)....

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1/6, 1956, to 1/7, 1956, that I last saw the deceasedalive on 1/6, 1956, and that death occurred at 3:00 p.m., from the causes and on the date stated above.

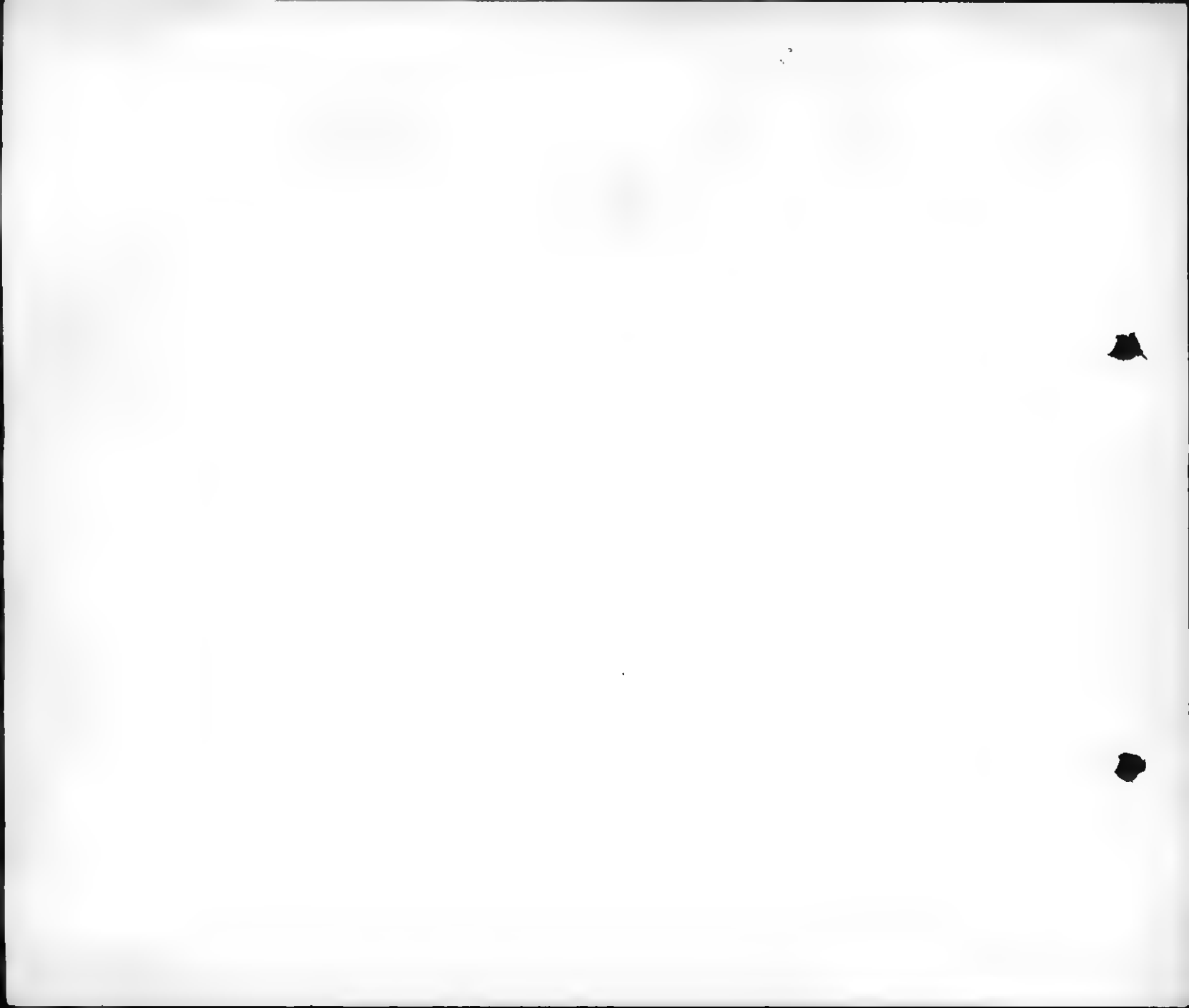
SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Jan. 9, 1956</u>	<u>Druid Ridge</u>	<u>Pikesville</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR ADDRESS		
<u>1/9/56</u>	<u>A. J. Fisher</u>	<u>Wm. J. Fisher &amp; Sons - Balto 17 Md.</u>		



394

CERTIFICATE OF DEATH

Reg. Dist. No. 44

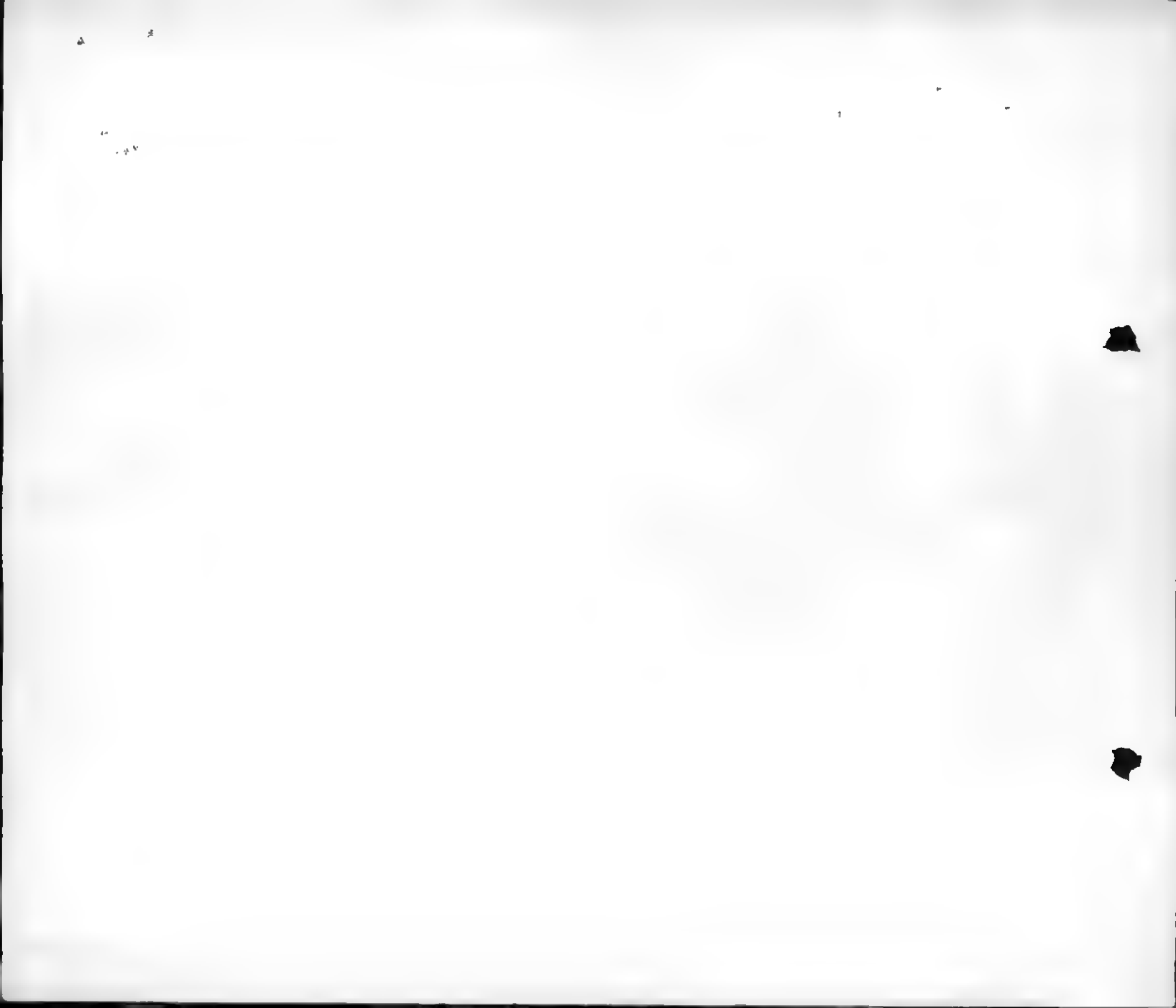
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <b>Fort Howard</b>	<b>27 days</b>	OR TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Veterans Administration Hospital</b>		STREET ADDRESS (If rural give location) <b>3216 Rosalie Road,</b>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<b>OTTO WEIBE</b>		<b>January 1 1956</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widowed</b>	8. DATE OF BIRTH: <b>10/27/79</b>
9. AGE last birthday <b>76</b> yrs.		10. UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Lithographer</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Paper</b>	
11. BIRTHPLACE (State or foreign country): <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>August Weibe</b>		14. MOTHER'S MAIDEN NAME: <b>Louise Bombardt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>Yes</b> (If Yes, give war or dates of service) <b>Spanish American Unknown</b>		16. SOCIAL SECURITY NO	
17. INFORMANT & ADDRESS: <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(A) <b>IRREVERSABLE SHOCK</b>		<b>40 HOURS</b>	
(B) <b>INTESTINAL OBSTRUCTION</b>		<b>2 WEEKS</b>	
(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>UNKNOWN.</b>			
19A. DATE OF OPERATION: <b>12/28/55</b>		19B. MAJOR FINDINGS OF OPERATION: <b>RIGHT TRANSVERSE COLOSTOMY FOR INTESTINAL OBSTRUCTION</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22 I hereby certify that <b>Dr. A. Gonzalez</b> attended the deceased from <b>12/5/55</b> , 19, to <b>1/1/56</b> , 19, and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.			
SIGNATURE <b>CARIDAD E. GONZALEZ</b>		ADDRESS <b>M.D. FORT HOWARD, MD.</b>	
DATE SIGNED <b>1/2/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
DATE THEREOF <b>Jan. 5/56</b>		LOCATION (C.ty, town, or county) (State) <b>Baltimore, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>1-4-56</b>		24. FUNERAL DIRECTOR <b>HARRY H. WITZKE</b>	
REGISTRAR'S SIGNATURE <b>[Signature]</b>		ADDRESS <b>1101 Edmondson Ave Baltimore, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.









MARYLAND

00391  
STATE DEPARTMENT OF HEALTH

396

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1111 1/2 St.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>JAMES</u> (Middle) <u>LEWIS</u> (Last) <u>WHALE</u>		(Month) <u>11</u> (Day) <u>3</u> (Year) <u>1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
			9. AGE last birthday yrs. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		<u>Unk.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		<u>U.S.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>James H. Harker</u>		<u>Janice Harker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	
		<u>None</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2</u> <u>2</u>
Immediate cause (a)...				
Antecedent cause(s) (b)...				
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)...				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
				Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11:00 am, to 1:30, pm, 1956; that I last saw the deceased alive on Jan 26, 1956, and that death occurred at 12:00 pm, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>2-1-56</u>	<u>Green Park</u>	<u>Green Park</u>	<u>Montgomery, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan. 31, 1956</u>	<u>Wm. E. Martin</u>	<u>Robert H. Wright</u>	<u>Sheltonville, Md.</u>	

MARGIN RESERVED FOR INDEXING

RECEIVED

FEB 1 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

397

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>	
TOWN <u>Catonsville</u>	<u>Life</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>902 Edmondson Ave.</u>		STREET ADDRESS (If rural give location) <u>902 Edmondson Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>AMOS WILLIAMS</u>		OF DEATH <u>Jan. 3, 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 15, 1887</u>
9. AGE last birthday <u>68</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Cook</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Catonsville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles Williams</u>		14. MOTHER'S MAIDEN NAME: <u>Agnes Harriday</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Benjamin Williams 2 Milbert Ave.</u>			
15. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Mitral Insufficiency</u>		<u>8mo-25d</u>	
ANTECEDENT CAUSE (B) <u>Hypertensive Arteriosclerosis</u>		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (M.)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-12-1955</u> to <u>1-3-1956</u> , that I last saw the deceased alive on <u>1-3-1956</u> , and that death occurred at <u>11:03 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Carl Maloney</u>		DATE SIGNED <u>1-4-56</u>	
M.D. <u>57 W. Baltimore Baltimore</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 7, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Wm. Hills Cem.</u>		LOCATION (City, town, or county) (State) <u>Celia Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-6-56</u>		REGISTRAR'S SIGNATURE <u>JW Hedrick</u>	
24. FUNERAL DIRECTOR <u>Mr. Kate R. Williams</u>		ADDRESS <u>Schneider St</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



398

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

COUNTY **Baltimore** MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) **Catonsville** LENGTH OF STAY (In this place)  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS **408 Thackery Ave**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Md.** COUNTY **Baltimore**  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Catonsville**  
 STREET ADDRESS **408 Thackery Ave** (If rural, give location)

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
**Stephen Yovanov**

4. DATE OF DEATH: (Month) (Day) (Year)  
**Jan. 19, 1956**

## 5. SEX:

male

## 6. COLOR OR RACE:

white

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

married

## 8. DATE OF BIRTH:

May 7, 1916

## 9. AGE last birthday:

39 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Merchant

## 10b. KIND OF BUSINESS OR INDUSTRY:

Self

## 11. BIRTHPLACE (State or foreign country):

Baltimore, Md.

## 12. CITIZEN OF WHAT COUNTRY?

US

## 13. FATHER'S NAME:

Dushon Yovanov

## 14. MOTHER'S MAIDEN NAME:

?

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

none

none

## 16. SOCIAL SECURITY No.:

216-01-9428

## 17. INFORMANT &amp; ADDRESS:

Margaret H. Yovanov, 408 Thackery Ave.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

Coronary Embolism

Coronary Disease

INTERVAL BETWEEN ONSET AND DEATH

12 hr

4 yrs?

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **12:26**, 19**55**, to **1:14**, 19**56**, that I last saw the deceased alive on **1:14**, 19**56**, and that death occurred at **10:45 P**.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

Baltimore, Md.

ADDRESS

Howard H. Hubbard, 4107 Wilkens Ave.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Ken. DeForest  
805 - Madison Ave

BUREAU V. S.

JAN 24 1956

RECEIVED

1

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01567

399

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sweet Air (Baldwin P.O.)</u>				TOWN <u>Sweet Air (Baldwin P.O.)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Green Rd. near Paper Mill Rd.</u>				STREET ADDRESS (If rural give location) <u>Green Rd. near Paper Mill Rd.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Carrie Irene Zinkhan</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Jan. 24, 1956</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widow</u>	<b>8. DATE OF BIRTH</b> <u>Jan. 12, 1877</u>		<b>9. AGE last birthday</b> <u>79</u> yrs.	<b>IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>John Young</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>None</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Chas. Zinkhan, Baldwin, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						<u>20 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Arthritis</u>						<u>5 yrs.</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>D. O. H. Medical Examiner notified</u> <b>to</b> <u>Jan. 24, 1956</u> <b>that I last saw the deceased</b> <u>alive on</u> <u>Jan. 24, 1956</u> <b>and that death occurred at</b> <u>9 A.M.</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>William G. Tyson M.D.</u>				<b>DATE SIGNED</b> <u>Jan. 24, 1956</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Jan. 27, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Prospect Hill Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Towson, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>1-29-56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Wm. G. Tyson</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John Burns' Sons, Towson, Maryland</u>			

# CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p> <p>2. Sex: _____</p> <p>3. Age: _____</p> <p>4. Date of birth: _____</p> <p>5. Place of birth: _____</p> <p>6. Date of death: _____</p> <p>7. Place of death: _____</p> <p>8. Cause of death: _____</p> <p>9. Signature of physician: _____</p>	<p>10. Signature of registrar: _____</p> <p>11. Date of registration: _____</p> <p>12. Place of registration: _____</p> <p>13. Signature of informant: _____</p> <p>14. Date of information: _____</p> <p>15. Place of information: _____</p>
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**BUREAU V. 5**

FEB 8 1956

**RECEIVED**